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# Journal of Solution-Focused Brief Therapy

Volume 1, Number 1 — 2014

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## EDITORIAL POLICY

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

The journal invites submissions as follows:

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

## Why a new journal of Solution-Focused Brief Therapy?

**Michael Durrant**

Back in 2010, there was a small meeting in Malmö, Sweden, that discussed the “future” of Solution-Focused work. It was a group of interested people and NOT a representative group at all. One shared concern was how we could make Solution-Focused more “respectable”, particularly in relation to the academic community, and how to advance the scholarly pursuit and examination of the Solution-Focused approach.

Solution-Focused Brief Therapy developed, not always comfortably, under the broader family therapy umbrella. The paper that first presented Solution-Focused Brief Therapy in a systematic way (de Shazer et al., 1986) was published in the respected family therapy journal, *Family Process*, and scholarly articles about Solution-Focused Brief Therapy have largely been published in family therapy journals, particularly *The Journal of Family Therapy*, *The Journal of Systemic Therapies*, *Families in Society*, *The Journal of Family Psychotherapy*, and others.

A few years ago, a professional association was formed by and for people using Solution-Focused approaches in organisational, business and coaching contexts. As part of its activities, The Association for the Quality Development of SF Consulting & Training (SFCT) publishes *InterAction: The Journal of SF in Organisations*. This is a peer-reviewed journal, with a clear scholarly focus and an editorial advisory board that withstands academic scrutiny. The journal is into its sixth year and is now included in a couple of the major academic journal databases.

We believe that the time has come for there to be a similar scholarly journal devoted to Solution-Focused Brief Therapy (rather than coaching or organisational consulting). The existence of a high-standard, specifically SFBT journal will hopefully assist the recognition of SFBT within academic circles and

help differentiate it from the broader muddle of different models that is the family therapy field. Further, since there is not yet any agreed-upon accreditation for Solution-Focused work, a peer-reviewed journal that accepts — and rejects — submitted papers will begin to help clarify (in broad terms) what the Solution-Focused community believes is, and is not, Solution-Focused work.

Dr Alasdair Macdonald and Dr Mark McKergow have been key supporters of this development, which has taken some time to reach fruition. The formation of the Australasian Association for Solution-Focused Brief Therapy (AASFBT) in 2012 provided the platform for the journal to move ahead. While published by AASFBT, the journal is by no means simply an antipodean project. Rather, the Australasian Association is publishing the journal as a service to the international Solution-Focused community — an international journal, published in Australia. We have assembled an Editorial Board of international breadth and are pleased that the papers published in this first issue represent six different countries.

My thanks to all who have worked to make this journal a reality.

de Shazer, S., Berg, I. K., Lipchik, E., Nunnally, E., Molnar, A., Gingerich, W. J. & Weiner-Davis, M. (1986). Brief therapy: Focused solution development. *Family Process*, 25(2), 207–221.

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As mentioned above, the impetus for beginning this journal was at a meeting in Malmö, Sweden in 2010. That meeting was organised and hosted by Björn Johansson and Eva Persson, from the Clues Centre in Karlstad, Sweden. Björn was an energetic Solution-Focused practitioner — not a therapist but involved in Solution-Focused coaching, Solution-Focused team building and other Solution-Focused work in the organisational context and in supervising and training social workers and public sector professionals. He was passionate about the approach and keen that Solution-Focused work should expand in both organisational and therapy contexts. Sadly, Björn died in June 2014, 48-years-old, following a struggle with cancer. While not a therapist, Björn would have been excited that the idea of this journal has finally come to fruition. I dedicate this first issue of the *Journal of Solution-Focused Brief Therapy* to Björn. The journal owes its existence to his vision for expanding the broad Solution-Focused community. We send our best wishes to Eva and Molly (who assisted at the Malmö meeting and so is an honorary SF person) and the family.

# Solution-Focused Group Work in Prison

**Britta Severin**

Social worker and Family therapist, Swedish Prison and Probation Service

Doing Solution-Focused work in prison, which is a very normative context, is a challenge. The request from the prison was distinct: to conduct a Solution-Focused group program, with inmates sentenced for sexual offences — “deniers” — in an open group. The miracle question, scaling, exceptions and tasks were useful in order to identify and take small steps while in prison, small steps that took the clients closer to their goals — which are always outside the prison walls.

I was asked to conduct a Solution-Focused group program in prison, in a ward for inmates sentenced for sexual offences against adults. The inmates were presented as “deniers” and they were sentenced to at least one year in prison. The conditions for the program were that it be an open group and, for my security, that a prison officer be present in every session, with different prison officers depending on their schedules. I was asked to conduct the program several times a week, but we agreed that once a week would suffice. I was not to do therapy, I was to conduct a Solution-Focused program — meaning, “do something”. Apart from that, I was free to form the program however I chose.

## History and Design of Project

At the time I was asked to conduct the program, in 2000, there was not much literature about working in a Solution-Focused manner with groups, especially not in prison, nor with sexual offenders. Lindforss and Magnusson (1997) implemented a study in Sweden on Solution-Focused therapy in prison. It

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\* An earlier version of this paper was presented at the European Brief Therapy Association Conference in Dublin, September 2001.

was a randomized controlled study. The prisoners had high recidivism rates and serious drug misuse. The study clearly showed reduced reoffending in the experimental group, who received SFBT. Lindforss and Magnusson estimated that the control group cost 2.7 million Swedish crowns more in prison costs than the experimental group during the follow-up year. But the study was based on individual therapy, not group work. The Plumas Project (Uken & Sebold, 1996), a Solution-Focused goal oriented domestic violence group program in California, USA, showed very good outcome. Individual interviewing was used in a group setting. The group met for one hour, eight sessions. I was struck by the simplicity. However it was not implemented in prison and not with an open group. I was also influenced by Jenkins' profound belief that change is possible (Jenkins, 1990). Jenkins works with perpetrators of violence and sexual abuse and he is incredibly attentive to the slightest little sign of responsibility and that the client wants a change.

Designing the program I built on Steve de Shazer's idea on doing things as easy as possible, the basic principles of Solution-Focused therapy (Berg, 1991; Berg and Miller, 1992; DeJong & Berg, 1997; de Shazer, 1988, 1991) plus my own ideas. I chose to interview each group participant separately, as in the Plumas Project, and to work on everybody's personal goal. The program was named "Sessions in Group", in order to clearly indicate it was not group therapy. I was used to doing Solution-Focused work with offenders (Berg & Dolan, 2001, pp. 75-78) and leaned on my experience from doing Solution-Focused work within the National Prison and Probation Service. I believed that the model can facilitate change for mandated clients (Uken et al., 1996), even clients in prison (Lindforss et al., 1997). Throughout the project I shared my ideas with colleagues, including Insoo Kim Berg. I continued to do whatever worked. What I did was pioneer work.

The project led to my co-presentation — on Insoo's suggestion — with Adriana Uken from The Plumas Project on "Working Successfully with Mandated Clients" at the EBTA Conference in Cardiff in 2002.

## **An Official Program**

As this was an official program, I needed a stated aim and I had to find one that the prison management, the inmates and I could accept. This was also a way of creating a framework for the program. I decided to say, "I come to this group to work with each one of you to diminish the risk of you ending up in prison again." That is how I started the conversation with the group and I repeated it whenever there was a new participant.

## Structure of Sessions

I chose to work with a group of four since this seemed to be a manageable number. It was also a request from the participants that there not to be too many members. I worked individually with each one of the participants, while the rest of the group and the prison officer were listening. Each interview took about half an hour per person. There was no specific topic for each session. I asked the same Solution-Focused questions as I ask clients in any setting. I used the miracle question, scaling, looked for exceptions and sometimes gave tasks. Since it was an open group new clients joined the program continuously. In each client's first session I asked the miracle question. The second and the rest of the sessions, I asked "What has been better since last time we met?" I wrote on large papers that I stuck on the wall, so everybody could see them. At the end of the session, I made a short closing statement for each person. After the very first session, one of the clients said, "These small conversations are good. I get the feeling this is the beginning of something new."

## Being Able to Influence

Being in prison means there are so many things one cannot influence. To introduce the thought of being able to influence and make choices, I asked the clients how come they decided to join the program. One client, in prison for the first time, was very upset about being sentenced to two years in prison and also about being reported by his wife. He was worried about not being able to see his two children grow up. I asked him "How come you decided to join the program?" He said he had been thinking, and that he had come in order to discuss what would be the best for his children. Should he see them while in prison? How could he contact them? A couple of sessions later, he said he had now come to the conclusion that he needed to work on giving the children a positive picture of their mother — after all, they would go on living with her.

## The Miracle Question and Scaling

It was crucial to connect the small acts of life inside prison to the client's dreams — which always are on the other side of the prison walls. Using future-oriented questions and scales was most helpful. The clients told me about their dreams and wishes — and they were like the dreams of everybody else; having contact with their children again, seeing their children



again, regaining the respect of their families, feeling better, having a job, getting an education etc. Those who had children had goals related to their children. My previous experience from using the miracle question in prison was that it was extremely difficult to get answers — it was like the prison walls were too thick! In the first session I used another future-oriented question. One of the clients said, “Oh, you mean, if a miracle happened?” After that I used the miracle question.

One client had spent most of his life in institutions. His answer to the miracle question was, “I wake up from a good morning kiss from my little daughter. I am there for my wife. I am there for my children. I am a father to my children.” He would also have a job and an income and there would be no drugs in his life. There had actually been a shorter period when he had a job and things worked pretty well. He said that making contact with his children again would be the first step. He had not seen them for over a year.

On a scale from 1 to 10, where 10 stood for when life was the way he wanted it to be, and 1 was when it was at it's worst, he was at 7. A couple of weeks earlier he had been at a 2. I asked him what he had done to reach all the way to 7. He said that he had been thinking and that he had come to understand that there were things he could not influence and he had managed to let go of them. He had also thought that there were other things he could influence, and had started doing more of those things. He had called his lawyer and the social services to ask what would be the first step towards getting to see his children again. He had kept working on what he needed to do and finally he was at the point where he actually was permitted to call his children. Now he did not know what to say to them and he worried about their questions. He was afraid he would start talking about how dreadful it was for him being in prison, and he did not want them to hear that. So what he did, was to sit down and think about what would be the best for his children — and then he wrote himself a reminder, “Ask the children about their school, ask the children about their friends, ask the children what activities they are involved in.” This man, who saw himself as being extremely impulsive, had managed to sit down and make plans. He had called his children and had managed to do exactly what he had planned.

## Small Steps

In order to get closer to our goals, we need to take small steps. One client felt extremely mistreated and had felt so for quite some time. He thought his sentence was unfair and he was busy writing to newspapers and appealing to the court to get a new trial. On a scale from 1 to 10, where 10 stood for

when life was the way he wanted it to be, and 1 was when it was at it's worst, he was at -1. After having acknowledged his difficulties, I asked him how he would know that he was just a little higher on the scale. He said that maybe, he would have been watching some TV. In the next session things were a little bit better. He told us that he had done other things besides pondering. He had watched sports on the TV, he had studied a little and he had started to socialize a bit more. In the following session he was at 4 on the same scale. He told us that he had five tapes about positive thinking in his cell, and that he had now listened to two of them. A couple of the clients asked if they could borrow his tapes.

## Exceptions and Tasks

Searching for exceptions was of course essential. "Maybe this will give me an eye-opener", one client said, when I asked him what would be a sign for him that it was worthwhile taking part in the program. He was not very cooperative in the first sessions but he kept coming. One day he said that he had had some "eye-openers", that I had given him the opportunity of thinking in an alternative way by saying, "If you were to...". He said that what really frightened him was that one day he would not be able to stop hitting when he was provoked and that he would eventually kill somebody. I asked him if he had ever felt provoked but did not hit the person. He looked at me and said, "In here or out there?" I said, "In here or out there." "I never hit my best friend", he said.

One of the other group members reminded him that he was provoked the other day by another inmate and that he had done nothing. I asked, "What did you do?" He said that he had walked away. I asked, "What made you walk away?" He said, "I was thinking 'It's not worth it, I have to behave'. I was thinking about my parents and that I have to behave in order to get a chance to be moved to a prison closer to my family, so they could come and visit me." He said that it was an absolutely new way of thinking for him, that he was able to control himself. At the end of the session he was given a task. I said, "Between now and next time I would like you to notice, very carefully, occasions when you could have been provoked to hit someone but you did something else. I also want you to observe what you do instead." At the next session he described more exceptions. And he added, that the prison was an excellent place for him to practice — there were lots of occasions when people provoked one another. And he kept on practicing thinking. After a while he said, that he had now practiced so many times that it had become a habit and that he did not get irritated any more. I asked what he did instead. He answered

that he was busy making plans for his future. The prison officer attending that day said that he had noticed differences during the last few weeks. The client was much calmer in the ward, had spent more time in his cell and was no longer involved in arguments.

## **The Group Participants**

The group turned out to be heterogeneous in many aspects. Since the prisons in general were overflowing, there were inmates in this ward who had been convicted for other crimes, for instance domestic violence and assault, and they also joined the group. Some of the clients were in prison for the first time in their lives, others had been sentenced 30-40 times, some had just arrived from custody, some had been in the ward for quite some time, some used drugs, some had a drinking problem, some were native Swedes, others not.

## **Building Collaboration with Clients**

These men were incarcerated for what most people regard as despicable crimes. Their status is low even in prison. It was crucial to treat them with respect in order to build collaboration. One needs to set aside one's personal biases and find out what is important to the client, see/address the person, not the problem. As in any other context it was important to meet the clients where they were. Some of them felt extremely insulted and mistreated. It was important to acknowledge them in their difficulties. Their goals were related to life outside prison, so I was curious about their lives, their families, their children, their interests, what country they were from etc. Throughout the sessions I gave them compliments whenever possible.

## **Building Collaboration with Staff**

The prison administration was all along very supportive. Building collaboration with the prison officers was important. They referred the clients. Before starting the program, I met with the staff for half a day to introduce them to the Solution-Focused approach. Every time I came to the prison, I passed by the ward to get a chance to meet the staff on duty and say hello to everybody in an informal way. The staff discussed new referrals and the new inmates got to ask me about the program. As Lindforss and Magnusson (1997) describe, conducting a project in a prison has side effects, makes a difference for the staff. The prison officers told me that the program had influenced them. Attending the sessions had taught them how to talk to clients in a different

way. They noted changes between sessions and discovered new sides of the clients. They also tried new things themselves. One prison officer had noticed that the inmates did a lot of thinking between sessions. He had also heard clients, in the ward, talk about their children, something he had not heard before. Another one had noted that one client, who had a very tough attitude in the ward, could also be sensitive and reflecting. One client who was really having a hard time, said in a session that for him the worst time of the day was after being locked up at night. The prison officer attending that session knocked at the cell-door of this inmate at night and they had a talk. One of the staff volunteered to interpret, even change his schedule, to enable one inmate to join the program.

## Evaluation

The group program was an official program and I was supposed to report back to the management whether the program made any difference for the clients. I asked for an individual written evaluation on the fifth session and on the last session. On the fifth session evaluation there were four questions:

- ◆ “On a scale from 1 to 10, where 10 stands for “Sessions in Group” has been helpful and 1 is that it has been absolutely worthless. Where do you put yourself?
- ◆ What I have done myself that I am pleased with.
- ◆ What the facilitator has done that I am pleased with.
- ◆ Other reflections.

On the last session evaluation there were five questions:

- ◆ “On a scale from 1 to 10, where 10 stands for “Sessions in Group” has been helpful and 1 is that it has been absolutely worthless. Where do you put yourself?
- ◆ What I have done myself that I am pleased with.
- ◆ What the facilitator has done that I am pleased with.
- ◆ What I have brought with me from the sessions that will be useful for me in the future.
- ◆ Advantages of group sessions — instead of individual sessions.

The clients put themselves higher on the scale in the final session than in the fifth session. Many put themselves on 8, 9 and 10 in the final session. The clients wrote, for instance, “I have come to realize how important it is to talk to

somebody when I get stuck and to think before I do things", "I have decided to change my life", "I've calmed down. I have learned to think before I act" and "I have learned how to control myself".

Many of the clients wrote that the questions asked by the facilitator were helpful, for example, "The facilitator asked a lot of questions, questions that made me think", "the questions made me think about things I have not thought of before", "the many questions made me think — about the past, the present and the future", "the questions made me think and I have realized there are alternative ways of reacting, these sessions have made me calmer", and "the facilitator made me think, her questions made me think, that is the Socratic way".

The clients also wrote, for instance, that the program had helped them understand that they could influence their lives, that talking about the future had been helpful and that their hopes for a better future had increased. They also wrote that it had been helpful to talk about their problems and that listening to other people's problems and steps forward had given them new perspectives..

### **Benefits of Conducting the Program in a Group/Group Process**

I must admit I initially rather would have seen the clients individually, not in a group and rather not in an open group. But that was what the prison administration had decided. I soon realized there were benefits in conducting the program in a group. The clients listened very carefully to what the other group participants said. They also listened to my questions and applied them to their own lives. Clients said they started thinking about their own scales and what had been better for them, when I asked other clients. The participants interacted with one another and they tried to help each other. One client asked, "Would you like to hear what I did in order to get closer to seeing my kids?" They also kept an eye out for the other clients' exceptions and when the other clients made progress, for example one client said, "I noticed that you have been much calmer this week." And they cared for one another. One client said to another that he was worried about him, because he was taking a lot of tranquillizers (prescribed by doctor) and said, "If you walk around like a sleep-walker, how shall you ever reach you goals?" The client came back the next session, more awake, saying he had cut down on his medication. Two of the other clients said that they too had cut down on their medication. The group participants wrote in the evaluation that listening to other participants' problems and steps forward had given them new perspectives. Lee et al. (2003) also describe benefits of conducting their project in a group and

of the interactive group process. Sharry (2001) addresses many aspects of group work in *Solution-Focused Groupwork*.

### **Working with sex offenders — “deniers” — in prison**

The group of clients that joined the program is not considered to be highly motivated. The clients were sentenced for domestic violence, assault and sexual offences. Those who were sex offenders were in addition “deniers”. Some of those clients felt extremely offended and hurt, because nobody believed them. They pondered and pondered. In order to be able to build collaboration it was extremely important to acknowledge them in their difficulties! Solution-Focused conversations offer a respectful way too build collaboration without confronting. Macdonald (2007) states that several studies show that Solution-Focused therapy is effective for offenders and other hard-to-treat clients, maybe because it is collaborative.

### **Challenging Contexts**

A prison is not the most hope-inspiring setting. It is very normative. There are lots of rules. Prison officers — and inmates — see many clients return after reoffending. The inmates have to make applications for almost everything. And they spend a lot of time waiting for the answers. Just to instil hope that change is possible is a challenge, both into inmates and prison officers. The program was offered to the inmates. The decision to join was up to them. One group participant said, “Joining the program was important to me. I think this is the first time since I came to prison my application was not rejected.”

### **The End of the Project**

The program was conducted for 1½ years. 22 inmates were referred to the program. Three of them were inappropriate referrals. One thought I could help him to get a leave — which I could not; one thought I could have an influence on his transfer to another prison — which I could not; and one did not want to participate in a group. One client came twice and was then transferred to another prison. 18 inmates attended at least four times. The program ceased as The National Prison and Probation Administration had decided that this group of inmates was to be transferred to other prisons, where other programs waited. Also, I was asked to supervise two groups of prison officers and to work individually with clients sentenced for violence (Severin, 2008).

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## About the author

Britta Severin has vast experience doing Solution-Focused therapy within the correctional system with clients with a history of violence. For nine years, she worked in prison with inmates sentenced for violent crimes, individually and in groups, and for more than twenty years she worked as a probation officer, working both with probationers and parolees. Currently, she is employed as a therapist by the correctional care at an outpatient clinic for alcohol and drug abuse. Most of her clients are on probation or parole, often sentenced for violence. She has also been training and supervising for many years.

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## A Taste of Wittgenstein for SFBT. 1: The *Tractatus*\*

**Nick Drury**

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Wittgenstein holds a special place in Solution-Focused Brief Therapy due, in no small part, to his idea that “... *problems are solved in the literal sense of the word — dissolved like a lump of sugar in water*” (2005, §421).<sup>1</sup> In the last twenty years there has been renewed interest by philosophers in Wittgenstein due to a relatively new perspective on his work known as the ‘resolute reading’ or the New Wittgenstein (Read & Crary, 2000; Fischer, 2011). This is the idea that Wittgenstein’s work can be looked upon as primarily a form of therapy for untangling knots or conceptual confusions in our thinking generated by philosophical assumptions, in order that we might be more attuned to the world and each other.<sup>2</sup> There is also a more subtle version of this, known as the ‘elucidatory reading’, which says not only are we more present as a result of this philosophical therapy, but we are also more aware of what gets us into philosophical knots (Hutto, 2003/2006). This may be of some interest to psychotherapists as they also have interest in dissolving problems so that people can get on with their lives more harmoniously. This, the first of two papers overviewing Wittgenstein’s work, focuses on his early work and life.

### Introduction

This paper attempts to weave a summary of Wittgenstein’s first efforts at providing a philosophical therapy within an account of his life, as I think it helpful in developing our understanding of his ‘philosophy as therapy’ to know a little of his life and times. However the danger in writing biographies (and no doubt summaries), one of his executors (Anscombe) once remarked, is that

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\* The second paper, “A taste of Wittgenstein for SFBT. 2: *Philosophical Investigations*”, will appear in the next issue.

1. All references to Wittgenstein will just include date, and page or aphorism number.

2. Although this may not be an explicit goal in SFBT, it is a useful idea for understanding Wittgenstein’s work.



the writer tends to drag his or her readers down to the biographer's level (Englemann, 1967, p. xiv). Therefore, I offer my apologies in advance.

## **From Vienna to Cambridge**

Ludwig Wittgenstein was born on April 26th 1889 as the youngest of eight children in the second wealthiest family in the Austrian-Hungarian empire (after the Rothschilds). There appears to be nothing in his school years to indicate the plaudit of 'genius' later bestowed upon him. Indeed, he was considered by some as the dullard in the family. The family homes were the centre of culture and humanity in Vienna, with the likes of Brahms and Mahler as regular visitors. Gustav Klimt painted a famous picture of his sister Margaret; and Ravel wrote a famous piece for a one-armed piano-player following his brother Paul's loss of an arm during the First World War. Ludwig himself was particularly adept at whistling long detailed musical pieces.

Although mostly home-schooled, he did attend a school briefly, which was also attended by Hitler. This led one writer (Cornish, 1998) to speculate that Hitler began his hatred of the Jews due to his schoolyard relationship with Wittgenstein (the Wittgenstein family had converted to Catholicism from Judaism two generations prior to Ludwig's birth); but the evidence for this is considered poor. The only subject in which he did well at school was religious studies, which — as we shall see — was significant; and he told a friend later in life, *"I am not a religious man but I cannot help seeing every problem from a religious point of view"* (Rhees, 1984, p.79). After completing the work described in this paper, he worked as a gardener in a monastery for a while, and considered becoming a monk.

It is perhaps noteworthy that three of his four brothers committed suicide, and he wrote at various times in his life of his own contemplations of this. He was not totally at peace with his homosexuality either, and his brother Rudi referred to his own "perverted disposition" in his suicide note. A good argument has been made that Ludwig was an 'exile' in numerous ways (Peters, 2008). He became an exile from Vienna and the Austrian-Hungarian Empire, his family from Judaism, and he spent time in self-imposed isolation in Norway and Ireland during his years as a philosopher at Cambridge. He often referred to himself as an outsider, e.g., *"The philosopher is not a member of any community of ideas"* (1967, §455). He was, in many ways, an anthropological participant observer of our industrial culture. Is this not the position Foucault (2001) indicates the therapist adopt in order to engage in 'fearless speech'?

Similarly, he had much sympathy for Oswald Spengler's *The Decline of the West*; the idea that with the rise of the Newtonian mechanical mindset

Western culture had fallen from a cultural peak achieved at the time of Bach. “*Music came to a full stop with Brahms; and even in Brahms I can begin to hear the noise of machinery*” (Drury, 1984, p.112). “[I]t isn’t absurd ... to believe that the age of science and technology is the beginning of the end for humanity” (1980, p.56); but “*perhaps one day this civilization will produce a culture*” (1980, p.64). In a letter to his friend Maurice Drury (a psychiatrist) in 1946 he said he was writing for people a hundred years from then, when culture might be returning (Drury, 1984, p.160).

When he was 24, he learned Danish so he could study Kierkegaard in the original language, especially the mystical idea of a ‘world soul’ (not something to be believed in so much as experienced) and, during the First World War, as a soldier in the Austrian army, he read Dostoevsky’s *The Brothers Karamazov*, learning the speeches of the character Father Zossima by heart. Later he told his psychiatrist friend Drury that there really have been people like Zossima “*who could see directly into the souls of other people and advise them*” (Monk, 1991, p.549). As he carried Tolstoy’s *Gospel in Brief* with him during the war, he became known as ‘the man with the gospels’. However, he made clear to friends that he couldn’t believe what Catholics believe, and Bertrand Russell reports he was harsh on Christians in general. Again, his interest appears to have been mysticism, in the sense of being at one with the world.

At the age of 19 (in 1908), he came to Britain as an aeronautical engineer, and has a propeller patent from this period. Three years later, he arrived unannounced in Bertrand Russell’s room at Cambridge to discuss the foundations of mathematics and logic. Russell invited him to his lectures and he was soon dominating these, and even pestering Russell after the lectures. Although Russell thought Wittgenstein was a genius, others thought he was a crank. By the time he was 27 (in 1916), he was severely criticizing Russell’s work.

## Philosophy as therapy

It could be said that the criticism of Russell and others was that Wittgenstein saw the purpose of philosophy quite differently. “*Philosophy is not a body of doctrine but an activity*” (1961, §4.112). Traditionally, since the time of the Greeks, philosophy in the West has been viewed as a “love of knowledge” or an attempt to grasp the essential nature of reality. Thus most of our philosophers have taken a position on various ideas, allowing us to categorise them as realists or nominalists, positivists or phenomenologists, etc. Whereas they wanted to paint a grand picture of the world, Wittgenstein was more bent on attuning us to the world, by untangling (or dissolving) the philosophical

knots in our thinking so that we could see (or be with) the world with clarity. It might be said, that for Wittgenstein, any theory or doctrine about the world was an indication of philosophical confusion; and as Bill O'Hanlon and others have said, "a hypothesis might accidentally enter a therapist's head and the best remedy for it is to lie down until it goes away" (1987, p.98).<sup>3</sup>

With the benefit of his later work, and the efforts of nearly a century of work by philosophers, we can now shed new light on his first attempts at philosophical therapy. For example, he was later to say that "[t]he work of the philosopher consists in assembling reminders for a particular purpose" (1958, §127). One "reminder" that Steve de Shazer (2005) used a lot was "*don't think, but look!*" (1958, §66). Another is the insight Wittgenstein brought to Cambridge with him, and was to feature prominently during the rest of his life; the idea that some words which have more than one meaning beguile us at times, as our attention can shift from one its meanings to another without us noticing. He called this the cardinal problem in philosophy (Kremer, 2007). "*Philosophy is a battle against the bewitchment of our intelligence by means of our language*" (1958, §109). To guard against being seduced by shifting meanings, his teacher Frege had warned him to pay particular attention to the context in which the word is being used. Remaining context focused (and not getting lost in your hypothesis) is a hallmark of Wittgenstein's work as it is in SFBT (de Shazer, 1994).

Another helpful reminder of where Wittgenstein's philosophical therapy is going, allowing us to make sense of some of the more difficult passages, is the claim by Moyal-Sharrock (2013) that the most important contribution he made was to revive the animal in us; that despite all our 'civilizing' we are still fundamentally animals. There is "something instinctive, thought-free, reflex-like" (p.263) about us; that most of the time our actions are not mediated by intellectualisations. Somewhat similarly, John Shotter (2004) has emphasised on the basis of Wittgenstein and others' work, that there is a spontaneous, embodied, anticipatory, mutual responsivity, occurring between us when we communicate, not only providing the context for our utterances, but also allowing us to complete each other's sentences at times. Although I am presenting Wittgenstein's work here largely as a theory or doctrine about human nature, Wittgensteinian scholars stress that this can generate the very philosophical traps that he is wanting to free us from.<sup>4</sup> He is wanting to *show* us

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3. Wittgenstein said: "Don't, for heaven's sake, be afraid of talking nonsense! But you must pay attention to your nonsense" (1980, p.56). Kierkegaard also comments on the difference in the ways people talk nonsense; that comes closer to the irreverence of Robert Anton Wilson's idea that bullshit is everyday nonsense but every now and then someone tries to force horse-shit on you.

something about our nature and life, rather than *say* how it is.

## Saying and Showing

His anti-theoretical position finds expression in his elucidations on the distinction between ‘saying’ and ‘showing’. Many in the SFBT community are familiar with Ben Furman’s metaphor of therapists as “pickpockets in a nudist camp” (Furman & Ahola, 1992); our task is to **show** people their own solutions, and we can’t *say* what they are prior to picking their pockets. In everyday life, if someone makes an error adding up numbers, we endeavour to **show** them the error in their calculations. Just as with SFBT’s solutions, many of Wittgenstein’s elucidations consist of **showing** us aspects of our own actions we hadn’t noticed before. Now an elucidation is like getting a joke or understanding a mathematical proof—we need to see it or ‘get it’. The elucidation doesn’t *say* (or **show** anything extrinsic to the joke or proof); the person has to use the elucidation. An elucidation (noun) doesn’t automatically elucidate (verb). Suddenly the duck becomes the rabbit, or the two faces become the vase, in those well-known ambiguous figures.

## The First World War and the *Tractatus*

The First World War interrupted the development of these ideas stemming from his arguments with Russell, so he returned to Vienna to enlist in the Austrian Army. During the war, he became a highly decorated officer, getting an Austrian medal equivalent to the Victoria Cross. He ended the war as a POW in Cassino, Italy, where he completed the manuscript for *Tractatus Logico-Philosophicus*. He ends this very short book (about 70 pages) with the comment, “*My propositions are elucidatory in this way: he who understands me finally recognises them as senseless, when he has climbed out through them, on them, over them. (He must so to speak throw away the ladder, after he has climbed up on it.)*” (1961, §6.54). This work, he believed, has essentially **shown** (for those who get the elucidations) how these various foundational ideas arise from out of doing logic and mathematics. As this work answers all the questions of philosophy, he thought he could now retire from philosophy and do something else.

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4. There is an immense trap that numerous constructivists and social constructionists have fallen into when they presented Wittgenstein’s ideas as a causal theory of social constructions. Such errors lead to a re-animation of the Cartesian ego endeavoring to manipulate social constructions (e.g., by law) rather than deconstructing these realities to see if alternative constructions might arise (a change in lore). See Francis (2005) and Shotter (1995, 2005).

However he had quite a bit of difficulty getting *Tractatus* published. It seemed that publishers expected a treatise on how the world *is* from philosophers, not one pointing out that we can't *say* how the world is. Part of the criticism of industrial culture, that he expressed in letters and conversations with friends, was that 'scientism' had taken over from traditional religion. Both had the effect of shifting attention away from this world to another world. Traditional religions to one of heavens and angels controlling the world from behind the scenes; 'scientism' to one of mechanical explanation — the idea that everything has a scientific explanation, and our attention is captured by imaginary laws governing the universe from behind the scenes. "*Science is a way of sending us to sleep, philosophy must serve to wake us up*" (1980, p.5). "*The whole modern conception of the world is founded on the illusion that the so-called laws of nature are the explanations of natural phenomena*" (1961, §6.371). "*Laws ... are about the net and not about what the net describes*" (1961, §6.35). "*There must not be anything hypothetical in our considerations. We must do away with all explanation, and description alone must take its place*" (1958, §109).

### ***Tractatus* — Facts**

Following these brief comments on his methodology and aim we can begin to look at the *Tractatus*, which was finally published in English in 1922. The *Tractatus* begins with the statement that "[t]he world is the totality of facts, not of things" (1961, §1.1). Now for most of us, having grown up in a culture when positivism reigns, and we think of ourselves as separate from a world we endeavour to capture in a net of reasoning (logic and mathematics), we would think that the world is made of things, and facts are our attempts to make sense of the things. However Wittgenstein makes sense here if we consider that the bird sees the cat as a cat, not as 'sense data' or an object (a 'thing') that it interprets as a cat (as Locke had argued). For living beings, our reaction is immediate and not mediated by interpretation (cf. 1961 §5.5423).

We live in a world of facts. When we look at those ambiguous figures like the Necker cube, the kissing vase, or the duck-rabbit, we see one or the other of the aspects. Looking at the Necker cube we don't see 12 straight lines and then interpret this one way or the other. We immediately see one of the cubes, and then with a slight shift in attention we see the other. In other words we see facts, or to say it slightly differently, our sense making is primary and not secondary. And as these ambiguous figures *show*, there are different ways of making sense. So what Wittgenstein is doing is helping us make sense of our sense making from within the world, not from an assumed ("objective")

position outside of the world (or apart from it). This was very difficult for his contemporaries to grasp as they were well entrenched in the ‘objectivism’ that positivism built its house on.

Now he goes on to point out that there may be regularities in nature but primarily they **show** themselves to us. In the duck-rabbit figure we see the duck, we see the rabbit, but we don’t see both at the same time. We obviously can’t step outside of the world and **say** (see or describe) both at the same time. We can of course do what I am doing here, describe what we are doing as we move from one viewpoint to the other, but we can’t, as his publishers expected him to do, **say** how the world is as a whole. *“If there were a law of causality, it might be put in the following way: There are laws of nature. But of course that cannot be said: it makes itself manifest”* (1961, §6.36). Twelve years later, when he was contemplating this puzzle again of what can be **shown** more than can be **said** he noted: *“What a Copernicus or Darwin really achieved was not the discovery of a true theory but a fertile new point of view”* (1980, p.18e). We could say the same of Einstein in comparison with Newton. They saw the ‘rabbit’ that hadn’t been noticed before. For Wittgenstein, science is descriptive, not explanatory.<sup>5</sup> As we have seen, his aim was therapeutic, and thus he wanted to get rid of all explanations as they take us out of this world to an imaginary realm about the world (which leads us to think we can control it). Wittgenstein’s elucidations help us stay attuned or present to the world, and allow us to see or understand ordering processes in a new light. He wanted to dissolve all the world views of previous philosophers. Different perspectives, like Copernicus or Darwin achieved is fine, but there is no one world view here. No argument with the creationists. *“Our craving for generality”* (1966, p.17) is a major source of confusion in philosophy.

Thus the aim of the *Tractatus* was to draw a limit to what can be **said**. During the three or four years it took to get the book published, he sent a letter to a publisher saying the book is made up of two parts. The part in writing, and *“everything I have not written. And precisely this second part is the important one”* (Monk, 1991, p.178). Hardly the sort of comment that might endear the work to a publisher; but if you follow the **say-show** distinction then everything of importance, i.e., ethics, aesthetics, human relationships, etc., **shows** itself to us far more than anything we **say** about it. This does not mean, as the logical positivists or Vienna Circle were to misinterpret him as saying, that everything other than the physical is not just unspeakable, but unreal. Later in his career, he was to place greater emphasis on the idea that although we cannot describe the ethical or aesthetic, we can express it. The

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5. See Drury (2006) for an account of Goethe’s ‘delicate empiricism’ as a method of science closer to Wittgenstein.

metaphors of religion, literature, and art are expressions of what we can *see* far more clearly than we can *say*. In the *Tractatus* he expressed it thus: “*There are, indeed things that cannot be put into words. They make themselves manifest. They are what is mystical*” (1961, §6.522). (The word ‘mystical’ stems from the Greek ‘muen’ meaning to keep silent.)

He then goes on to describe how we present these ‘facts’ in our language, and at this point introduces us to the idea that language pictures the world. (In his later writings (1930 onwards) he expresses some regret in restricting the use of language to picturing or representing reality in the *Tractatus*, for of course there are all sorts of other ways language is used — giving orders, asking a question, thanking, etc., (1958, §23). However, we might say that empirical science’s primary function is to present descriptions of the facts. [But even there, a Wittgensteinian writer, Spencer Brown (1969), argues that science and mathematics are primarily prescriptive — ‘look down a microscope’, ‘drop a perpendicular’]). However, during this early period, he was in agreement with Russell that propositions (statements of facts) picture the world, and so both had an interest in the structure of propositions (i.e. logic). Russell thinking that this structure (logic) is discoverable (laws of thought), and Wittgenstein trying to show they are inventions.

Russell, who took the positivist position outside or apart from the world, thought there must be ‘meta-propositions’ (propositions about propositions, i.e., ‘logical objects’), which he expressed in his theory of logical typing. But for Wittgenstein, who saw himself as a participant in the world, there were no ‘meta-propositions’ that were grounded in reality. For Wittgenstein, the structure (logic) of our propositions reflect the expressions of our perceptions, which as we have seen with the Necker cube or duck-rabbit, can vary. (Although at the time of the *Tractatus* he thought propositions had a general form. He was later to regret that.) Just as the elements of a portrait are arranged in a way to resemble the person they represent, the structure of our propositions resemble the aspect we are seeing (the duck or the rabbit). They say more about us than the world (Shotter, 2012). He said that his fundamental idea is that this order cannot be *said*, but *shows* itself (1961, §4.0312). He argued with Russell, saying that we are limited in only being able to *say* empirical propositions; we are only able to describe facts in the world. If we try to *say* something about the structure of the world, and this includes so-called scientific laws, we are stepping out of the world into some sort of meta (-physical) realm, and this generates all sorts of ghosts and conundrums such as an infinite regress of laws behind laws. Thus Wittgenstein distinguishes what can be *said*, the propositions of science, from what can be *shown*, the so-called logical objects that Russell thought he was dis-

covering that connects different propositions together. As we shall see, this **say-show** distinction is not limited to the so-called logical objects, but also to all the important things to us as people — ethics, aesthetics, religion, art, music, and understanding people. If you like, it is preferable to regards these things as **showing** themselves in their expression than in what they **say**. A case of actions speaking louder than words.

The upshot was whilst Russell thought, in keeping with the scientific or positivistic traditions of our culture, he was discovering real ideas (that lay the foundations for mathematics and logic [and “*mathematics is a method of logic*” {1961, §6.234}], and so were real things for Russell); Wittgenstein thought it more useful to consider these ideas as senseless (although not useless) artefacts that come from the social activity of doing mathematics or talking logically. Once you see this aspect (what we now call the ‘socially constructed’ nature) of these ideas, you will see they are essentially senseless, in that they do not refer to anything tangible that resides in the world. One of the ways he did this was to **show** us that the so-called propositions of logic are tautologies (“*I know nothing about the weather when I know that it is either raining or not raining*” (1961, §4.461)); they **say** nothing about the world as it is. However talk about the weather **shows** that raining and not raining structure both language and the world. Then, as he proceeds he goes on to **show** us that his own arguments or propositions about logic are also meaningless, but if we get what he is **showing** us, then they are not entirely useless.

## Mathematics and logic as social constructions

Possibly, because most Western intellectuals position themselves as observers of the world, rather than participants, they seem to struggle with this idea that mathematics and logic, which “*look like a fact of nature*” (something we discover) are better considered inventions (1978, II, §37). “*I shall try again and again to show that what is considered a mathematical discovery had much better be called a mathematical invention*” (1976, p.22). Money is of course such an invention, or what we would now call a socially constructed ‘reality’ — as these pieces of paper, plastic, or metal obtain their value or ‘reality’ through the tacit agreement we have through using them. As Searle (1995) says, “the very definition of the word “money” is self-referential” (p.32). Social realities are made up of constitutive rules, not regulative rules. Or intrinsic or tacit rules, not extrinsic or explicit laws. Lore not laws regulate social realities. We can deconstruct (lay open to view) social constructions, and that may lead us to play or construct different realities, but we can’t step outside them (cf. Shotter, 2012 for a discussion on the relationship to Whorf).<sup>6</sup>



Understanding this difference between intrinsic and extrinsic rules we can see how Wittgenstein thought Russell and his cohorts were treating philosophy as a science aimed at (*saying*) discovering the foundations of logic and mathematics, what Boole before them called the 'laws of thought'. By contrast what Wittgenstein wanted to do was *show* us how we are creating these apparent (mathematical and logical) 'truths' in doing mathematics or speaking logically.

We don't need to explicitly know formal logic to speak logically; language existed long before there were logicians, and even little children who are competent language users can distinguish nonsense from sense. A useful way to see how mathematics is an invention rather than discoveries is to consider mathematics as being like other inventions, especially the microscope or a pair of glasses. These are all useful inventions for helping us see facts that we might not have seen without them. They help us extend our perceptual power. Also we learnt how to double things or cut things in half long before we had or learnt numbers. Numbers and mathematics was a useful invention to give expression to what we were doing when we cut something in half.

When we learn chess, mathematics, or even everyday things like good hygiene, the rules are an expression of the game or way of life; the rules are not independent of their application.<sup>7</sup> But we all too easily turn these intrinsic regularities into external rules that must be obeyed (cf, 1961, §6.37). This seems especially so if we have had a fright of some sort or believe these rules to be causal. It is not difficult to discover this kind of shift has occurred in those difficulties some call phobias and obsessions. For example, the expression of good hygiene has taken on a demand characteristic after the intrinsic rules have been separated from the activity (Heaton, 2010).

## **The *Tractatus* as Therapy**

We might say then, that through studying the *Tractatus* we come realise that we are already aware of the logic of our language due to our everyday use of it. *Tractatus* is primarily a therapeutic text helping us see that everyday language is perfectly suited to our needs, and the idea that we need a theoretical account of logic is just part of a widespread confusion that we need any theory at all (Parry, 2009). Once we have dispelled the idea that we need any theory, including the ones of the *Tractatus*, then we can express or act more ethically

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6. See note 4 on page 5.

7. Daniel Everett's *Don't Sleep, There Are Snakes* (2009) provides a readable account of a missionary's discovery that Chomsky's universal grammar doesn't apply to the Pirahã people of Brazil.

(even if we now have no theoretical justification for these acts!). Surely, I hear you say, if we have no world-view then we have no basis for acting ethically, and this ‘therapeutic philosophy’ is going to bring further chaos on the world!

This is where we return to Wittgenstein’s interest in Kierkegaard and Schopenhauer. Because we had been standing back from life, trying to understand it theoretically, or capture the world in a net of reasoning, we had been avoiding or evading the everyday requirements that life makes on us to act. We had been sitting in academic ivory towers philosophizing, and ignoring the plight of those around us. What actions we were taking, were being mediated through some world-view or philosophy. The therapy of the *Tractatus* transforms us, so that our ‘will’ is now more directly and immediately engaged with life. We are now more present to life. It’s a therapy that leads us to see that our attempts to formulate, what we thought was the ‘problem of life’ (e.g. that the universe appears to have an order that can be known objectively to us), as well as the attempted solutions that came from those formulations, has just led us into greater confusion. Liberated from this confusion, we are now more committed to acting with resolution. (We might say we become more disciplined.) This is called the ‘resolute’ reading of Wittgenstein (Read & Crary, 2000; Fischer, 2011; Bronzo, 2012). When Wittgenstein concludes the *Tractatus* with the famous injunction “[w]hereof one cannot speak, thereof one must be silent”, for the resolute reader this silence is ‘pregnant’ as we are primed to act. Some draw a parallel here with Heidegger’s writings on authenticity (Cahill, 2004).

## On having no head

One of the things dissolved (like sugar in water) by the *Tractatus*, is the ego or sense of being a Cartesian self (“I think, therefore I am”), separate from the world. Nietzsche had seen that the “I” is an artefact of the noun-verb structure of grammar, and has no more existence than the “it” in “it is raining”. Hume too, saw that there was no ego or self that is an object of experience. The thinking subject is not an entity that is separate from what he or she thinks — “*There is no such thing as the subject that thinks or entertains ideas*” (1961, §5.631). If you like, there is thinking or seeing going on, but no one who is thinking or seeing (no little homunculus inside your head). The Cartesian error had come about because we can distinguish an empirical or objective subject — the person I see in the mirror and other people, and the apparent subject who (we tell ourselves) must be doing the seeing and thinking. When we start introspecting we can get the two confused, as Descartes did.<sup>8</sup> Dissolving this confusion, we see “I” is a pronoun, not a noun.

Wittgenstein's way of dissolving the self (or 'I') in *Tractatus* was by leading us through an argument on a form of solipsism. Solipsism is the idea that I alone exist; I am creating the whole world. (It is a difficult doctrine to argue against, but fun to imagine a conference of solipsists arguing as to which one of them is really there!) He starts out by noting that "*what the solipsist means is quite correct; only it cannot be said, but makes itself manifest*" (1961, §5.62). That is, we can take the view that "*The world and life are one*" (1961, §5.621). Or, "*I am my world*" (1961, §5.63). We see this solipsism in the child who says after anaesthesia, "*They stuck a needle in my arm and I disappeared*". Or another of Wittgenstein's ways of pointing at it: "*At death the world does not alter, but comes to an end*" (1961, §6.431). So you might ask, where am I, or where is the subject in this world that I am? Well, "*[t]he subject does not belong to the world: rather, it is a limit of the world*" (1961, §5.632). Alternatively, "*You will say that this is exactly like the case of the eye and the visual field. But really you do not see the eye. And nothing in the visual field allows you to infer that it is seen by an eye*" (1961, §5.633). However experientially the eye or "I" is not outside the visual field. That is to say, there is "*no part of our experience [which] is at the same time a priori*" (1961, §5.634). It is not in the experiential field, and it is not outside it; it is the experiential field ("*I am my world*"). As one Zen Buddhist writer noted, it is living life as if one had no head (Harding, 1961).

So as we begin to understand this, a psychological transformation occurs and we feel our sense of self shrinking to nothing or expanding to the limits of our experiential field (as far as my eyes can see and ears can hear). "*The self of solipsism shrinks to a point without extension, and there remains the reality coordinated with it*" (1961, §5.64). Kremer (2004) says this is the self-emptying described in religious experience, where by becoming nothing or shrinking to an extension-less point (or by becoming everything), God, Dharma, the Tao, the Force, Al-lah, (etc.), can enter in.

## Doing 'God's' Will and 'Divining'

'But surely,' you say, 'I have my will, and that is separate from the world'. On this point Wittgenstein agrees — "*The world is independent of my will*" (1961, §6.373). However we can easily be led into an egotistical trap here (one that is fuelled by our culture's 'scientism' or Cartesianism). We often exercise our will by predicting what is going to happen, and then taking action. (Although more frequently there is not two things, planning and acting, but

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8. Wittgenstein (1961, 1966) refers to the often unnoticed slippage that occurs between the use of "is" as verb and then as an adjective to show how this confusion occurs.

just one — “*The act of the will ... is the action itself*” (1984, p.87, 4.11.16).) Note however, there is no certainty here. “*The events of the future cannot be inferred from those of the present. Superstition is the belief in the causal nexus*” (1961, §5.1361). A meteorite might plunge through the roof before I finish typing this sentence. “*There is no compulsion making one thing happen because another has happened. The only necessity that exists is logical necessity*” (1961, §6.37). So although I might make predictions and exercise my will, it is only by the grace of the universe (in not sending meteorites through my roof), that these work out for me. “[A] favour granted by fate, so to speak” (1961, §6.372).

So we might say, as some religious texts do, that there are two ‘wills’ in play here, mine and God’s (or the universe’s). “*There are two godheads: the world and my independent I*” (1984, p.74, 9:7:16). If mine is in accord with the universe’s will then things work out happily for me, but if not, the universe, so to speak, pushes back against me. “*In order to live happily I must be in agreement with the world ... That is to say: ‘I am doing the will of God’*” (1984, p.75, 9:7:16). When the universe pushes back, my world shrinks, as I am the boundary (or limits) of my world; and when I am in accord with it, my world expands. “*If the good or bad exercise of the will does alter the world, it can only alter the limits of the world, not the facts — not what can be expressed by means of language. In short the effect must be that it becomes an altogether different world. It must so to speak, wax and wane as a whole. The world of the happy man is a different one from that of the unhappy man*” (1961, §6.43). “*Feeling the world as a limited whole — it is this that is mystical*” (1961, §6.45).

Thus, the *Tractatus* has enabled us to see an ethical position that is quite unlike Descartes (1637/1998) dictum to be “the masters and possessors of nature” that now so characterises positivistic industrial culture. For the laws that we sought to discover that would enable us to manipulate nature to our will turned out to be “*about the net and not what the net describes*” (1961, §6.35). But, by emptying ourselves or attuning our will to the universe, as most religions had taught in some form, our sense of self expands to experience the universe more. It is not possible to say what the limit of this expansion might be. This ethic is an ecology of mind (Bateson, 1972).

Dowsing is the art of divining for water, and provides us with a sense of this word ‘divine’. Goethe developed this as a method of science, an alternative to Newton’s, which he called the ‘delicate empiricism’. For Goethe, we become the scientific instrument, by making ourselves one with the phenomena we wish to understand, feeling it out from the ‘inside’ so to speak (Drury, 2006; Seamon & Zajonc, 2006). As I have shown elsewhere, this is an approach to science and psychotherapy that is also far more consistent with some indig-

enous 'ways of knowing' (Drury, 2011). And it is this that the *Tractatus* has **shown** us is of importance, not what can be **said**.

## An End of Philosophy

Now Wittgenstein delivered this into the citadel of the church of Western 'scientism', and it is of little wonder that few understood him. To utilise a metaphor from his later philosophy, a place had not been prepared for it. Perhaps amusingly, when he was giving his oral defence of the *Tractatus* for his PhD at Cambridge in 1929 he patted his examiners Russell and G. E. Moore on the back, saying, "*Don't worry, I know you'll never understand it.*" He told Drury that it would take about 100 years to be understood, and maybe we are seeing this as the 'resolute and elucidatory readings' catches the intellectual interest.

By the time he returned from the war in 1919 he was one of the richest men in Europe, due to his late father having invested the family fortune wisely. He also believed that he had answered all the important questions of philosophy and there was no need to pursue it further. So in keeping with his religious ideas or teachings he gave away his entire fortune, mainly to his siblings, and began training as a schoolteacher. He insisted on living the rest of his life like a monk, and went to teach 'peasant' children in the poorest of Alpine villages. After getting sacked as a teacher in 1926 for hitting children, he worked for a while in an Austrian monastery as a gardener (living in the tool shed). Despite numerous invitations to return to Cambridge, he saw no value in it. Later in that decade he formed a business partnership in Vienna, with his old Cambridge friend and fellow Austrian, Engelmann, as architects; and together they designed and had a house built for Wittgenstein's sister Gretl. This was to be his new career.

Besides the *Tractatus*, the only other things he ever published in his lifetime were a children's dictionary when he was teaching; a book review of Coffey's *The Science of Logic* in 1913; a short paper in 1912 entitled "What is philosophy"; and an article entitled 'Some remarks on logical form' in 1929 (that he characterised as short and weak (1993, p.156). Since his death numerous lecture notes, notes taken by students at lectures, notebooks, and a manuscript he was preparing have been published. It is perhaps highly noteworthy in these times of 'publish or perish', that he managed to publish so little and still be regarded by many as the most important philosopher of the 20th century.

## The *Tractatus* and SFBT

As de Shazer made clear in a number of his writings, SFBT does not have a philosophical theory underlying it, and Wittgenstein's work does not provide the (missing or hidden) theory. For both there is nothing hidden. But Wittgenstein is useful in helping deconstruct many of the positivistic assumptions therapists have been socialised into, and once understood, his aphorisms can serve as helpful reminders. For "*Nothing is so difficult as not deceiving oneself*" (1980, p. 34e), (especially I might add, in a culture where positivism reigns). As noted above de Shazer uses Wittgenstein's aphorisms as reminders to remain observant of what is going on, especially with the language actually used by the client, staying on the surface and not giving in to the urge to dig deeper for an underlying pathology, and such like.

For the positivist the idea that talking about solutions as a way of talking our way out of problems may appear superficial, but from Wittgenstein's elucidations on how we socially construct the realities we inhabit it seems clear that all therapies are endeavouring to do this in one way or another. Not only that but Wittgenstein's elucidations on the boundaries of what is being socially constructed shows that there will always be phenomena occurring that have not been enlisted into a social construction. In SFBT we express this by saying that change is always going on, or the solutions are already present in our client's lives, and questions about exceptions may elicit candidates for the solution-focused construction. Similarly questions about how clients cope with such a problem may show more clearly strengths and resiliencies that the client is possibly bringing to the solution.

Wittgenstein's elucidations on ethics also remind us of our way of being in therapy. The difficulty here is in showing this; for: "*It is clear that ethics cannot be put into words. Ethics is transcendental. (Ethics and aesthetics are one and the same)*" (1961, §6.421). When we look at Wittgenstein's way of life we begin to glimpse what he means by this. One of the richest men in Europe, with the equivalent of a Victoria Cross, gives away all his money and is living in a gardener's shed — what is he showing us? In his *Notebooks* he had written: "*I cannot bend the happenings of the world to my will: I am completely powerless. I can only make myself independent of the world — and so in a certain sense master it — by renouncing any influence on happenings*" (1984, p.73, 11.6.16). This is quite a different attitude to Descartes "masters and possessors of nature", which we see in applied behaviourism.

In SFBT we express Wittgenstein's ethic by reminding ourselves not to be working harder than the client; or as Brian Cade expressed it "It is important never to be more enthusiastic about the need for any particular change than is the client" (Cade, 2013). Our task is to be present and responsive. Our ethics express themselves, or can be seen in how we are *involved* in what we

say and do, not in what we say (Diamond, 1991). (*"What expresses itself in language, we cannot express by means of language"* (1961, §4.121).) That is to say, it is our attitude that is ethical, but as *"I am my world"* (1961, §5.63), I can't step outside it and say it without it becoming an injunction. *"When an ethical law of the form, 'thou shalt ...' is laid down, one's first thought is 'And what if I do not do it?'"* (1961, §6.422). Numerous writers have described this attitude in different ways. Anderson and Goolishian (1992) called it the 'not knowing' position, Shotter (2012) calls it 'dialogicity', and Ogden (2013) 'relational mindfulness'.

Now in therapy, we are also inviting our client to be responsively present, for we are inviting them to an attitudinal shift. When the client shifts from being a 'victim' to being a 'survivor' a shift in attitude has occurred. I construct a different world as a survivor than I do as a victim. *"The world of the happy man is a different one from that of the unhappy man"* (1961, §6.43). As we have seen Wittgenstein doesn't subscribe to what we now call the 'discourse determinism' view of social constructionism (Francis, 2005). As with other animals, with suffering there may be groaning, crying, wincing, or shaking going on; but for us humans it is only when I begin describing what is happening that social constructions begin. (Not only the groaning and crying, but also the spontaneous acts of resistance (Wade, 2007).) When we take the view that it is not so much behaviour that is subject to reward and punishment as it is attitude (cf., 1961, §6.422), then the 'relationally mindful' atmosphere creates space for these alternative constructions to occur. By allowing ourselves to be changed by the therapeutic conversation as much as the client (albeit in different ways), the conversation may take on a life of its own. We are now more likely to show how we are being affected by the client's stories, rather than pass judgement on them. We see this frequently in Insoo Kim Berg's simple utterances of 'wow'.

### **The therapy didn't elucidate some ...**

During the late 1920s, whilst working as architect with Engelmann in Vienna, Wittgenstein was invited to meet with the Vienna Circle, who were developing a philosophy of science based on the *Tractatus* called Logical Positivism. He endeavoured to stress upon them that the important part of his work was in what was not said, and at times even turned his back to them and read the mystical poetry of Tagore to stress the point. However it soon became apparent to both that they were singing from different song sheets. The positivists had positioned science as the pursuit of truth and philosophy as the pursuit of meaning — but Wittgenstein realised that this positioned

philosophy as the pursuit of truth about meaning, and thus made philosophy into science. He realised that the claim in the *Tractatus* that all propositions have a general form, an essence if you like, was misleading, and it was this that was driving the Vienna Circle and others to search for **the** method of science. He began making plans to return to Cambridge ... .

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## About the author

Nick Drury is a New Zealand psychologist with 3 children and 3 grandchildren. He grew up on a Waikato dairy farm reading Freud, Marx, and Nietzsche, and playing many sports. He ran his first marathon at 15. After losing himself to the '60s, he emerged as a psychotherapist and has been in practice for more than 35 years.

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## **Using SFBT in Hong Kong: Initiatives from Hong Kong Master of Counselling psychology students and implications for cultural contexts in Australia\***

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Solution-Focused Brief Therapy (SFBT) is a therapeutic approach which was developed primarily based on Western culture, beliefs and ideals. Six Master of Counselling Psychology students in Hong Kong participated in a clinical practicum for one semester during which they had the opportunity to apply the principles of SFBT with Chinese clients. The paper commences with an overview of the development of SFBT and counselling in Hong Kong, followed by the cultural context considerations. Three case examples, in addition to the learnings, cultural challenges and experiences from the student counsellors are provided. The implications for the use of SFBT in the Australian cultural context are briefly discussed.

When introducing Solution-Focused Brief Therapy (SFBT) to a culturally different group to the one in which it was designed, the new context, philosophical values and beliefs all need to be taken into account. A group of Master of Counselling Psychology students in Hong Kong undertook a clinical practicum during which they explored the use of SFBT with a diverse range of clients, including children with special needs and disabilities, adolescents and mental health clients. This paper will commence with an overview of the development of SFBT in Hong Kong, followed by a brief discussion of the Chinese cultural context. Next, three case examples where SFBT has been applied by the Master student counsellors with real life clients will be provided. Each case study uses pseudonyms and permission was obtained from parents to use the drawings in presentations and publications. Then the challenges of using

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some of the SFBT techniques, specifically, giving compliments and the use of the miracle question will be explored. Finally, brief implications of using SFBT within Australian cultural contexts will be discussed.

## The Development of SFBT in Hong Kong

The first SFBT training program was conducted in Singapore and Hong Kong around 1999–2000 under the leadership of Insoo Kim Berg. The original training team included “Brian Cade, Michael Durrant and Therese Steiner” (M. Durrant, personal communication, 2014). In 2004, the Academy for Solution-Focused Therapy Training was established and in 2006, the “Academy... organized the first Asia-Pacific Solution-Focused Conference” (M. Durrant, personal communication, 2014). In 2006, a second academy was formed and was named the Brief Academy (M. Durrant, personal communication, 2014). At this time, SFBT did not have a very big following and some negative experiences in using the miracle question created a poor reputation for its usefulness. Furthermore, most counsellors and psychologists were not aware of and subsequently did not use SFBT. However, today, both organizations have continued their presence and involvement in events held nationally and internationally (Durrant, 2014). There were also some local publications written in Chinese including *Solution-Focused Therapy: Social Work Application* (Ho & Chu, 1999), *Solution-Focused Therapy: Practice and Reflections 1* (Ng & Ho, 2003) and *Solution-Focused Therapy: Practice and Reflections 2* (Ho & Lau, 2003).

## Counselling Training in Hong Kong

Counselling in Hong Kong began in the social welfare sector during the 1950s (Lai & Mak, 1996; Leung, T., 1990; Moir-Bussy, 2006; Shek, 1999). This was in response to the unrest and riots that had been triggered by the Cultural Revolution with a consequent increase in social issues, especially child and youth delinquency. Churches and social welfare agencies sought to address these problems. Leung (1999) noted that the first counselling service was The Federation of Youth Groups, which was “an experimental counselling program staffed by counsellors returning from training programs in the United States” (p. 77). In the 1970s, counselling began to be included in Diploma and Master of Education training programs and the Chinese University of Hong Kong formed the Hong Kong Professional Counselling Association. In early 2004, the Asian Professional Counselling Association was founded by Professor Catherine Sun Tien-Lun and Ms Tse Pui Chi, along with a team of enthusiastic

counsellors.

The first formal Diploma Course in Counselling was offered at Hong Kong Shue Yan College in 1976, with the commencement of their Diploma in Social Science (Counselling and Psychology). HK Shue Yan College became a University in 2005 and by then was offering a four year comprehensive degree in the form of a Bachelor of Social Science Honors (Counselling and Psychology). In 2010, the University commenced a Master of Counselling Psychology and it was within this course that SFBT was taught by the author, and students engaged in a clinical practicum using SFBT during their internship. The discussions from class, and the learning from the first six students who undertook this clinical practicum in SFBT form the basis for this paper.

## Cultural Context

Chinese people are conservative, authority dependent, (Ho 1996; Ho, Peng & Chan, 2002; Sun, 2008) and are generally hesitant to go to counselling in Hong Kong. They tend to resist changing cognitive thoughts and insist on preserving their traditional knowledge and rituals. Furthermore, because mental illness is seen as a weakness or imperfection, there is a stigma attached to those who attend counselling to seek help for mental problems (Chung & Wong, 2004). Additionally, the Chinese regard the interdependent self as much more important than the individual self, deriving "its self-esteem from the ability to restrain self, and to adjust to and maintain harmony with the social mores" (Sun, 2008, p. 56). Another key facet of interpersonal relations is the notion of Face (*mian zi*), whereby the Chinese self-in-relation must gain face, give others face and not cause others to lose face (Hu, 1994; Sun, 2008). Hence, acknowledging that a member of the family needs to go to counselling and seek help from an outsider could cause a family to lose face in the sight of others. Help-seeking is passive, or not actively sought, leading to an increased reliance on family and friends. If a decision is made to ask for assistance, families are inclined to seek help from a social worker because the social work profession is better known in comparison to counselling. However, both counselling and the social work professions are viewed as an authority and the expectation is that professionals within these disciplines would provide the answers needed.

In terms of the learnings and cases presented in this paper, the counselling psychology students realized that there was a need to change the clinical alliance from a dependent one to a collaborative one. They also recognized that it would be more appropriate if they could shift the Chinese tendency from relying on fate and collectivism (Leung, 2010), to a more holistic approach where

clients could recognize they had strengths and the ability to solve difficulties within their own families in a positive way.

## Language and Translation Challenges

The translation of terms into Chinese can sometimes lead to a misunderstanding. For example, the translation of Solution-Focused Brief Therapy into Chinese is 短期焦點解決治療 which means short-term/focused/solution/therapy and 尋解導向治療 seeking for solution/direction/therapy. In Confucianism, names determine roles and responsibilities. Therefore, “The rectification of names (zheng ming) signifies living up to one’s roles and responsibilities by being proper in one’s language and behaviour; that is observing social propriety” (Sun, 2008, p. 13). Therefore, the Chinese translation of SFBT may create a fallacy that counsellors have the power to solve all problems and that it is their role to do so. Consequently, Chinese clients may have formed the impression that the counsellor would take all the responsibility and initiative to provide solutions and answers in SFBT. The counselling psychology graduates met such challenges in a creative way as they addressed the difficulties that arose because of language, translations and the expectations of their Chinese clients.

## The Education System in Hong Kong

The education system in Hong Kong provides 12 years free and universal primary (6 years) and secondary (6 years) schooling. There are approximately 568 primary schools, 542 secondary schools and 61 special schools. Children with Special Educational Needs (SEN) are allocated to schools based on the severity of their need (Miho, 2013). If they are diagnosed with severe SEN and have multiple disabilities they are enrolled in Special Schools, otherwise they go to mainstream schools. Diagnosis and assessment of these children’s needs follows the medical model. The needs of SEN students are often unrecognised, and if the children are in the mainstream school they may experience at times, teasing and lack of support (Miho, 2013). Teachers’ roles include teaching, class administration, guidance, discipline and counselling. If the teacher is unable to deal with the problems of the child with SEN they are often sent to the Guidance and Discipline teacher. Generally teachers and parents work together to remediate the difficulties, to provide compensation for the child’s weakness and to reduce the barriers in learning. In some cases the parents become over protective and highly involved in their children’s care and tend to push the children to achieve at a high level, even though it is

beyond their capability. The case of YL demonstrates one application of SFBT with a special needs child. The counselling psychology student was assigned to work with this child with special needs.

### Case 1: SFBT with a Special Needs Primary School Student, YL

YL (pseudonym) was a nine year old girl who lived with her parents and her younger sister. Her mother was the primary caregiver. YL had been diagnosed with expressive language disorder, Chinese dyslexia and attention problems. She was studying in a mainstream school. Her mother presented YL as having poor learning motivation because she delayed doing her homework and then when she did start she was spending long hours doing it, including her revision for dictation and spelling. Her mother also claimed that YL was not compliant at home and sometimes had tantrum behaviours. It was reported that she was teased by her classmates.

In the first five sessions, the student counsellor used a psychodynamic approach with little success or progress. In the sixth session, the counselling psychology student having learned SFBT, began to use SFBT with the child. At the beginning of this session, YL commented that she remembered what they had done in the previous sessions, so the student counsellor complimented her on her good memory thereby identifying one of YL's strengths, and building further rapport. The student counsellor also incorporated techniques of Art Therapy (Nims, 2007) for the scaling questions and for goal setting to help induce hope in the young girl. Another way of helping YL to set her goals was by using syntax rearrangement, for example:

- ◆ 這場比賽很精彩，運動員們很努力 — *This competition is very exciting. Athletes are very hard-working.*
- ◆ 這場比賽越來越精彩，運動員們越來越努力 — *This competition is more and more exciting. Athletes are more and more hard-working.*

This rephrasing gave her the insight that things can gradually become better.

Furthermore, Nims (2007) noted that art was an excellent tool for helping children to make a picture of what is going on in their life right now and to show what they would be doing that would indicate that things were better. So YL was asked to:

- ◆ *Draw a picture of what you would like to talk about;*
- ◆ *Draw a picture of what is going on right now; and*
- ◆ *Draw a picture of something you would like to change.*

The first picture (see Figure 1) that YL drew was of her sitting at her desk. Her

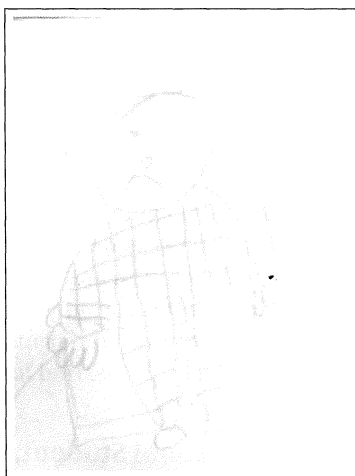


FIG 1: YL sitting at desk, face glum

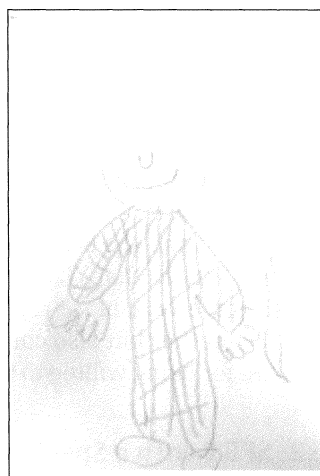


FIG 2: How YL would like to be

face was glum and there was no smile. She talked about the difficulty she was having at home and at school. The second drawing (see Figure 2) depicted a girl with a smile and showed that the change she wanted to make was to become a happy smiling girl.

YL also loved Sprite drinks so the notion of scaling used in SFBT was drawn up for her to colour in using a Sprite bottle (see Figure 3) – the two shades representing the change after a few sessions. In the fourth picture (Figure

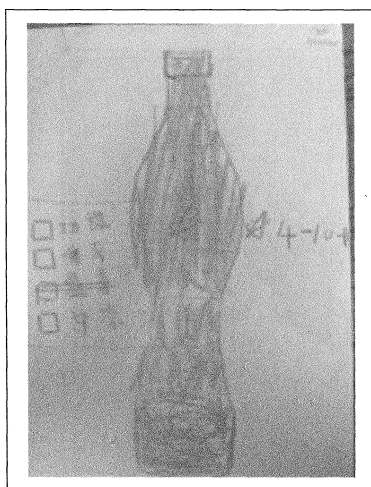


FIG 3: Sprite drink bottle scale

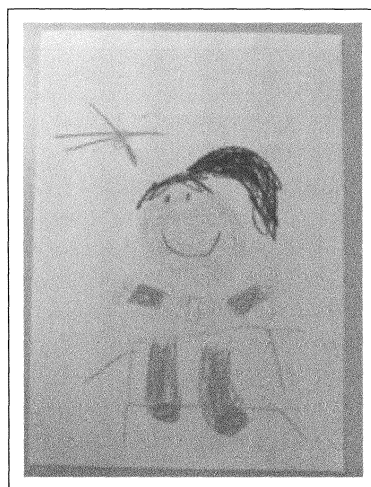


FIG 4: YL happy doing homework



4) shows the goal setting of doing her homework without being pushed and getting much better marks in dictation – all of which she achieved.

In the later sessions, the student counsellor invited her mother to join and showed her how the use of SFBT language and ways of encouragement could assist YL to keep improving. This was not an easy task, as many Chinese mothers want so much for their children to be perfect. The mother attempted to give more praise and, as she did, YL's behaviour and attitude to her homework improved and she became much happier. At the last session the mother proudly announced that YL had obtained 80% in her dictation and was now doing her homework more readily. The student counsellor not only complimented the mother but also complimented YL for knowing what her mother wanted and for being willing to work toward what her mother desired for her.

### Case 2: SFBT with a Special Needs Secondary School Student, CN

CN (pseudonym) was a boy aged 13 years and was enrolled in Secondary 1 in a mainstream school. He lived with his parents and younger sister. His mother was the primary caregiver. The guidance teacher in the school referred him to the counsellor, as CN had reported to her that he had insomnia, and it was also noted he had insufficient self-esteem to cope with the change to secondary school.

The student counsellor creatively designed worksheets to help CN express himself and to evaluate how much confidence he had at the commencement of counselling. The first worksheet below (see Figure 5) was designed to set CN's goals and to assess his motivation level to resolve the presenting con-

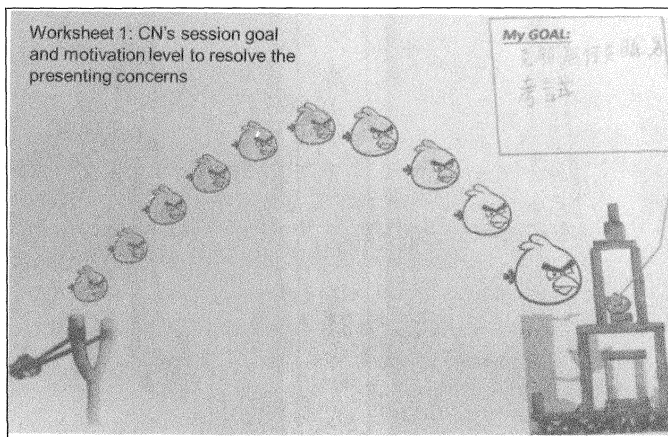


FIG 5: The Angry Bird Scale for CN

cerns.

This picture helped CN to be more concrete about his goals, and to visualize where he wanted to be — free from insomnia and increasing in self-confidence. The student counsellor also wanted to assess CN's stress levels and

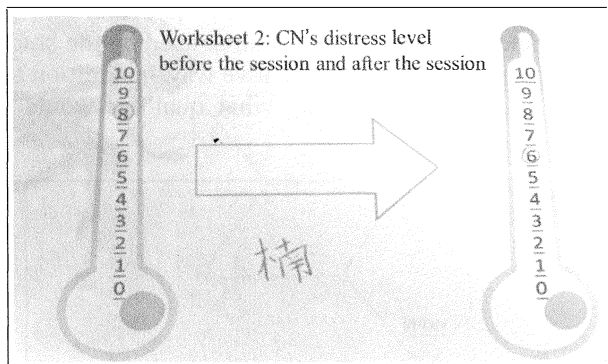


FIG 6: CN's scale for stress

again used a worksheet (see Figure 6) at the beginning and at the end to compare the difference.

A further worksheet (see Figure 7) was used to apply the miracle question and to help CN become aware of how he wanted things to be by focusing on awareness of his sensations, feelings and actions and who else would notice the change. Norum (2000) stated that in order for therapy to be successful, the client's cognitive awareness and sensation awareness about themselves are crucial factors. Therefore, the imagination of the client's ideal stage was

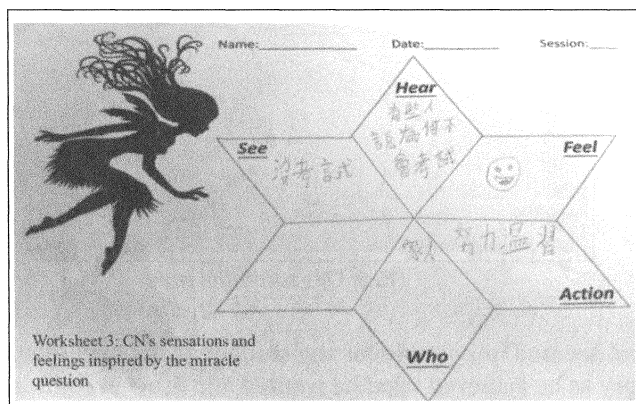


FIG 7: CN's practical goals

formulated with several sensations (hearing, seeing and feelings). These are in the worksheet below and helped CN to have a deeper acknowledgement of what he wanted, and to be more realistic and grounded about his ideal life.

Once his vision of the preferred future was established, the goals became more concrete and levels of stress and confidence to achieve his goal were scaled (see Figure 8 and 9). The creative pictures used by the student counsellor helped CN to express himself in a positive way. In addition to this, CN was encouraged to list his strengths and what qualities would help him achieve his goal.

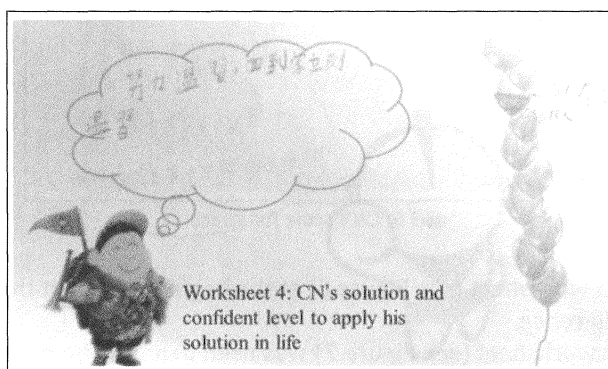


FIG 8: CN's practical worksheet

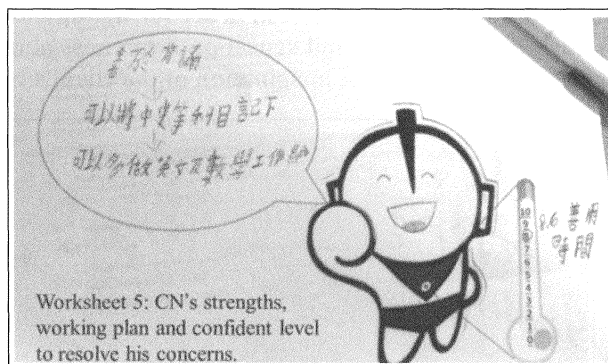


FIG 9: CN's successful story

What had seemed impossible for the student at the beginning was now a success story as he achieved what he wanted and grew in confidence.

## Application of SFBT in a Mental Health Setting

One of the students, who was a mental health nurse, was interested in how SFBT could be used with mental health patients. The focus in treating mental health issues in Hong Kong is very much based on the medical model and on the use of medication. According to Bakker, Bannink and Macdonald (2010), SFBT is effective in crisis intervention. While SFBT can be very useful in crisis intervention, it is important that clinicians understand the status of the psychiatric emergency and the needs of the clients. Anguilera (1998) has a model for dealing with psychiatric emergency, whereby the client's current status, behaviours, and the situation conceptualized by the client, are seen as the client being unable to identify a coping mechanism or social support. Therefore, the orientation of the intervention is to assist the client to find better coping mechanisms and to provide social support. SFBT is particularly useful for these cases. Psychiatric emergencies need quick therapeutic outcomes, which is more likely when the interventions are simple and straightforward (Callahan, 2009).

### Case 3: SFBT with a Client Experiencing Suicidal Ideation

A client presented to the student counsellor with suicide ideation. The woman was 39 years old and had suffered from postpartum depression for a number of years.

The student counsellor adopted some of the SFBT techniques learned during studies. Part of the transcript from one of the therapy sessions is provided below.

Client (C): I have had suicidal thoughts since 9 years ago, and the ideation is still active. I was thinking I would jump from a height yesterday.

Therapist (T): Can you tell me more?

C: My life is too painful. No one loves me and supports me. Every time, when I am talking about my issues with my husband, he just talks with me for a while, and then shifts the topics to a topic related to our son. He usually feels that I am troublesome, and create problems all the time.

T: Many people, who feel they are being ignored by their significant others, would feel painful (*Normalizing*). On the other hand, you must love your family and husband a lot. Maybe, you are noticing the problem, because you want the couple relationship to have some growth (*Complimenting and noting the importance of relationship with Chinese clients*).

C: Yes ... *(Sobbing)*

T: Tell me about a time that your husband did not ignore you, when you were talking about your personal issues with him? *(Exception question)*

C: ... I don't know ... He always ignores me.

T: So, when was the last time that you felt a little less ignored or had better communication with your husband? *(Exception questions)*

C: Last week. When I was talking about the side effects of my anti-depressants

T: Wah! How did you manage to do that? *(Coping Question)*

C: I talked to my husband sincerely. Unlike other episodes in which I would have a temper tantrum, I did not scold my husband for not noticing my side effect. I just told him that my side effect bothered me a lot. Then, he showed much concern for me, and we discussed it for nearly half an hour.

T: I would like to ask you a strange question ... imagine ... you sleep very well tonight ... a miracle happens while you are sleeping ... the miracle creates for you the way to have perfect communication with your husband ... it happens while you are asleep ... so you are not aware it happened, but when you wake up something is different ... so what changes do you notice after you wake up? *(Miracle Question)*

C: I would be very happy. My life would be more colourful. My husband and I would go traveling with our son, and both of them are very supportive to my depressed mood.

T: On a scale of one to ten, with one referring to the worst situation, while ten is equal to the miracle ... How do you rate your present status? *(Scaling question)*

C: I would say "4"

T: So ... what things would you need to do and you are willing to do, so that your situation would be a little bit closer to ten, and higher than 4, and you are more willing to survive? *(Coping Question)*

C: You know ... my bad temper can ruin our communication, but it is not easy to control it, when I am talking to my husband. Instead, however, I would try to develop a better communication method with my husband. For example, I can write my feelings in a diary and show it to my hus-

band. When he understands my situation, then I would feel being loved by him, and I would be more likely to live better (*solution*).

At the end of this conversation the patient's mood was lighter and she felt she could now go home and cope better. She stated she no longer felt suicidal and in the follow-up sessions she showed that she had developed better coping patterns and was no longer having suicidal ideation.

## Managing Cultural Challenges with SFBT Techniques

A key principle in SFBT is the use of compliments. Western clients tend to be reasonably comfortable with this but Chinese clients or clients from other Eastern cultures sometimes have difficulty with the notion of being complimented. People of Chinese cultural background consider humility as a virtue and are not used to receiving direct compliments (Yeung, 1999). They often show self-depreciation in response to compliments. One of the student counsellors experienced great difficulty accepting a compliment and explored this with us in class. Additionally, the student found that some clients also responded with embarrassment or seemed uncomfortable and even rejected the compliment. The student began to wonder if it was an effective technique. In the group's discussion they decided it was important to maintain modesty maxims, which meant clients would avoid expressing proud or non-humble feelings. They all agreed that establishing a strong rapport with the client was essential before using compliments. Use of words and phrases needed to be culturally appropriate and they concluded that clients would benefit from:

- ◆ Compliments for efforts instead of achievements;
- ◆ Compliments about their personal qualities (e.g. patience) instead of accomplishments; and
- ◆ Appreciation of their efforts to contribute to those with whom they were working. This places emphasis on the self-in-relationship.

If the client were to repeatedly reject the compliment, they felt they could then address this with them and talk about the reasons for this.

Another common SFBT technique is the use of the miracle question, which also posed difficulties for some Chinese clients. A miracle was something impossible and not pragmatic, or was associated with religion. According to Yeung (1999) there are two Chinese translations of the word miracle — *qi ji* and *shen ji*. Because Chinese words are pictographs, one needs to understand the composition of the characters in the pictograph and what they connote. Yeung notes:

The character of qi is an ideograph that is made up of two words, which are da meaning 'big' and ke meaning possible or accept. In Chinese culture qi means, from its written form, 'something big is possible'. Therefore the central idea of qi ji is anything can happen to those who believe in its possibility. (Yeung, 1999, p. 7)

By explaining this to a client and then giving an example of how the client's mother had believed it possible for her son to become a doctor, Yeung was able to help his client engage in the miracle question.

The counselling psychology students felt that many Hong Kong Chinese had a strong sense of a higher power and that they believed in heaven (天), god, faerie (e.g. 黃大仙, 關公), who can protect them. So one example of their miracle question incorporated this belief:

Imagine ...you visit Wong Tai Sin temple today, and you worship at Wong Tai Sin. Your effort impresses the faerie. At night, while you are sleeping, he removes all of your troubles and stressors by his super-power. On the next morning, how is your world different; what does it look like, and what changes do you discover?

Another example the students used with adolescents was to get them to see themselves as the director of their movie and so they put the miracle question like this:

I am going to give you a task. In the task you are the director and the actor in a movie. The name of the movie is "Your future". You are responsible for all of the things about the movie. You are free to edit it and decide everything about how you want to see yourself in your future movie ... You have now finished making the movie and you are watching it. What can you see yourself doing in the movie? What is this world of the movie like?

## Conclusion

The foregoing examples of the work achieved in SFBT by a group of counselling psychology Master students in only one semester in Hong Kong, demonstrates how they were conscious of the cultural context and of not just superimposing a Western therapy on Chinese clients. They see the value of SFBT with Hong Kong Chinese, as the people are typically very pragmatic and want to be able to achieve solutions quickly. The same principles they applied of

paying attention to the cultural values of their clients can also be applied in multicultural Australia.

Having worked with Indigenous people over a number of years, much of what the Chinese students achieved can be adapted to this group. Indigenous people are also very much other or family oriented – they too are a self-in-relation culture and family relationships are crucial. We can draw on this value to assist them in finding the solutions and preferred future they want. We can utilise and link their strong relationship to the land so they may create their preferred future. So too with other multicultural groups, attention to their context, their values and their philosophical backgrounds is crucial for the successful use of SFBT in counselling.

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Ann is a Level 4 registered counsellor and supervisor with the Australian Counselling Association (ACA) and is also the Vice President of ACA. She has published numerous peer-reviewed articles on counselling education and other topics in counselling. Ann has also presented at many conferences both nationally and internationally. Ann has supervised both Master students of counselling and PhD students.

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## Group supervision in Child Protective Service: Utilising the miracle question

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In the United States, child protective workers often find themselves in an adversarial relationship with families. They usually carry out indirect work monitoring set treatment plans and making referrals to treatment or intervention programmes such as parenting courses and anger management which have limited effectiveness in reducing risk behaviours. In this descriptive study, a group of child protective workers have undergone Solution-Focused training in direct work with families and are receiving Solution-Focused supervision. The use of the miracle question is outlined in detail as an example of how workers can be encouraged to move towards a more positive, hopeful practice.

*The true sign of intelligence is not knowledge but imagination.*

— Albert Einstein

Asking the *miracle question* is a significant method of working when engaged in Solution-Focused practice and can be considered when doing supervision (de Shazer, 1988, 1991; de Shazer & Dolan, 2007; Pichot & Dolan, 2003). This technique is reflective of a basic shift in the manner of engaging clients and in this case, supervisees. Solution-Focused practice places the supervisees in the position of being the expert on themselves and their work. This paper focuses specifically upon the use of the miracle question in a Solution-Focused group supervision session with child protective workers (Wetchler, 1990; Selekman, & Todd, 1995; Junke, 1996). It is intended to demonstrate how the use of this technique can expand workers' creativity, broadening the

child protective service workers' perspectives, and enabling a specific worker or group of workers to see beyond the immediate problem or impasse to gain potentially helpful insights and ways of approaching the situation.

The participants in this paper's example are engaging in a research project on the use of Solution-Focused practice in their work with children and families. The group is being trained in Solution-Focused child protective services (CPS) by the author during bi-weekly training and consultation. Some details have been altered, and the location and setting of the work has not been revealed, to protect confidentiality.

In the research project we are undertaking, we have altered the work of the CPS staff to taking on more direct work with the families. Rather than doing indirect work of monitoring set treatment plans consisting of referrals to programmes, workers are being trained to engage the families, using Solution-Focused work, in designing their own set of behavioural changes that will create the safety needed for the CPS worker to close the case. Obviously, this might include additional services such as drug treatment, mental health services, parenting courses, and anger management programmes. However, many of these chronic families have attended numerous parenting and anger management classes without making significant changes.

The focus in the setting of this research is on CPS workers working directly with the family on their desired future of having their children remain with them or having their children returned from foster care. Very specific Solution-Focused work is done by the worker with the family members to identify particular and detailed safety behaviours as goals which the family must accomplish to create safety. Plans for simple, clear behavioural steps toward a goal of safety are laid out, with the family participating in setting their own unique goals, working with exceptions and setting small steps toward the goal of safety.

## Moving from supervision to collaboration

Solution-Focused work is a collaborative practice that engages the client in a two-way relationship and perceives clients to be the experts on their life and experiences. When working with 'supervisees', collaboration rather than supervision is more representative of this process. Supervision connotes control and command over something or someone. A form of *power over* is assumed even if it is not overtly intended. Collaboration connotes a discussion between two or more people and the basic idea is *power with* or *between* two or more people. *Power with* connotes that all participants have power in terms of their ideas and experiences having equal authority in the conversa-

tion. This does not deny the fact that supervisors do have specific agendas, given their designated roles and responsibilities in the agency. At the same time, both the worker and supervisor recognise that the intention is to provide guidance, reflection and support.

Solution-Focused supervision within mental health settings, child protective services, addictions and other social service agencies recognises this basic nature of the relationship and is a collaborative interaction focused on the worker's competencies, while potentially expanding clinical awareness. Obviously, the supervisor or consultant is required to confront and stop any unsafe practices and address ethical issues. Competent and ethical practice requires consultation and ongoing learning. Competence by means of modelling and enhancing self-awareness or an ability to reflect on one's own actions and beliefs is one key to growth as a professional child protective worker.

### **Underlying principle: Engaging the worker's competencies and modelling**

Solution-Focused practice takes a different perspective on engaging others around challenges. Rather than uncovering the problem history and underlying pathological relationships and development of irrational thinking, the work is focused on finding out what the client's desired outcome of the work will be when the problems are gone or much better. Once again, the focus is on how to engage clients in a manner that prompts them to create possible futures from within their own life narrative and culture. A caveat here is that when trauma has occurred, or an unalterable crisis has or is taking place, the shift is to coping and what it will take to come to terms with the consequences of this traumatic event and health issue.

The collaborating supervisor, just as the Solution-Focused practitioner, uses various tools of Solution-Focused practice, one of which is *respectful curiosity*; whereby the supervisor is always curious about how the worker sees and understands the situation. O'Connell (2003) describes this curiosity stance as one that:

... prompts the supervisor to find out how best to co-operate uniquely with this supervisee. The exploration will encompass the supervisee's own preferred learning styles, use of language, prior experience of supervision, stage of professional development, personal qualities and context (p. 90).

Respectful curiosity takes the form of questions in solution-focused work. Sharry (2001) refers to solution-focused questions as *constructive questions*

because they “generate new experience about potential solutions and the strengths and capabilities of the client” (p. 33). The miracle question is just such a constructive question. It requires imagination reflective of the life experience of the client or, in our case, the CPS worker. The miracle question engages the imagination of the worker and is focused on a desired outcome or goal. When we think of goals, desired outcomes of our life, these are most likely positive outcomes, possibly overcoming a difficult situation. When people think in this manner it creates a sense of hopefulness and positivity. Groopman (2004) has noted that when considering a positive or desired outcome, hope is generated, and hope involves:

... affective forecasting—that is, the comforting, energizing, elevating feeling that you experience when you project in your mind a positive future. This requires the brain to generate a different affective, or feeling state than the one you are currently in (p. 193).

Another important and basic Solution-Focused construct is that the ‘problem’ does not happen all the time, in every moment (other than a chronic or fatal condition). A mother does not hit her child every hour of every day. A child does not skip school every day. Anxiety and depression ebb and flow during the day. All of these moments when the challenge is not as severe or is not present are referred to as *exceptions*. These exceptions are examples of what strengths and capabilities the individual has within his or her own repertoire and possible ways of acting that lessen the problem and create a better moment, a possible future.

## Why the Miracle Question?

There are many ways to focus the supervisory interventions when working with a practitioner. In the following example, uncovering the clinician’s strengths and possible solutions to issues he or she is facing with a client becomes both a model for working from a Solution-Focused perspective with clients while helping the supervisee uncover his or her own creativity and possible solutions to the challenges in this particular case.

The future-directed positive narrative is constructed through respectfully curious questions about desired outcomes or what will be different when there is a resolution of the problem. The miracle question (de Shazer, 1988; de Shazer & Dolan, 2007) is just such a question and a way to encourage the child protective service worker to think creatively about possible ways of working with the client. It helps the members of group supervision and the supervisor to build a new narrative, one different from the problem-satu-

rated narrative. Stepping out of the embedded negative narrative provides an opportunity to consider a wide range of possibilities, including simple overlooked data or facts lost in the negative focus (Berg & De Jong, 1996).

Insight and creativity are reduced when a person is engaged in negative thinking and affect (Compton, & Hoffman, 2013). When the worker's thinking becomes dominated by the negative experiences, cognition is narrowed in terms of possible alternative steps to make things change for the better. The miracle questioning by the supervisor provides an opportunity for the worker to take the lead in creating a different possible outcome. Rather than taking on the responsibility of knowing the 'right thing to do' and taking away the initiative from the worker (and potentially making an uninformed decision), using the miracle question can give the supervisor and the worker the opportunity to consider possibilities that they may never have considered, to recognise exceptions lost in the frustration of a negative narrative, which may create insights for potential actions to resolve the challenges.

This is possible by the use of the *constructive questions* discussed above; those that ask clients to develop a narrative about a possible future and desired outcome rather than questions about the past and descriptions about the problem, its history and its intensity (O'Hanlon & Beadle, 1999). When asked to consider a 'miracle', the child protective worker has the opportunity to articulate ideas that he or she might not otherwise consider. Most of us will censor our ideas and evaluate them before expressing them. This is particularly true if the person thinks of an idea and then assumes it will not work or is unacceptable and, self-censoring, refrains from mentioning it.

The miracle question is asked in a specific way and is intended to open the narrative. Because it can initially appear fantastical, it allows for greater creativity and possibilities to be expressed. In this instance the worker, as well as all other members of the group, is asked to imagine finishing a day's work, going home and doing what she normally does until she goes to bed. Then she falls asleep. But while she is asleep a miracle happens. The miracle is that this impasse, challenge or problem is gone, but she does not know it since she is asleep. Then the worker is asked: "What would be the first thing you would notice that was different with this family that would tell you that the miracle has happened?" "What would be different?" (specifically asking for details of this difference). "What would your client be doing differently? What would you be doing differently?"

When the desired outcome or preferred future is described, a new set of possibilities are voiced that are positive and help generate more creative thinking for all present in the group consultation. Not only the worker but the other workers in the group familiar with the family and the challenges in

working with them contribute insights and ideas. Most often a different and hopeful perspective is gained about the family and their actions, even where cynicism had taken over.

As these are discussed and shared it can be followed by one of two questions. The first is asking if there had been any time during the work with this family that any part of this miracle had ever taken place. This is a possible exception to the problem. The focus then is on descriptions of behaviors that were positive, such as the family was cooperating and taking necessary actions for safety even in small ways.

Now the questions become “What was different at that time? What was the family or client doing differently? What was different about the situation or context of the client’s life in any way?” Being engaged with CPS workers and other systems bring about significant changes in the life context of the client. Things are not ‘normal’. “What might have contributed to this difference taking place? In what way were you different with the family?” By looking at the situation from the perspective of exceptions or positive responses to the work (and the worker) opens the door to removing some of the negativity that has built up around the family.

Then the supervisor can ask, “If this was possible, how or what needs to happen that might re-engage this more positive behaviour?” The response to this can range from: the family feeling supported and thus making efforts to change; life circumstances changing and creating better opportunities for the family; or a specific interaction with the worker that moved the family in a positive direction. In some of these situations, the worker might have engaged the family in ways that were more helpful and it is important to identify what was most helpful in making the work more successful.

The opposite is also true. What might have the worker done or others done inadvertently that disrupted the relationship and had a negative response from the family? When asked the miracle question and then given the opportunity to explore the situation from a broader and positive perspective, the worker opens doors to insights that might point to possible new understandings of the impasse. Obviously, the focus is usually on the family taking action. The family is seen as the ‘patient’ or the one that is problematic, leaving out the worker and the staff who might not recognise the consequences of actions they have taken (although not intentionally). By stepping back, the worker and members of the group can gain insight into their own work and the context of the family’s life within protective services.

The fact that some part of the miracle or desired outcome had taken place becomes the ‘exception’ to the problem narrative and is the start of a possible positive and desirable narrative about the future and potential success.



Starting with small successes or steps that create a more helpful working relationship can assist the clinician in taking steps to change the work with a client. The positive narrative now described replaces the negative narrative and provides an opportunity to ask how that positive, hoped-for narrative (describing the desired working relationship), might be brought about if it has not taken place previously. This is an opportunity to critically evaluate the process but in a more positive, creative and hopeful manner. It also is based on the worker's own ideas and insights. When this is done in a group consultation, all members can participate and gain from increased creative thinking and input into the exploration of the challenging situation.

### **Supervision protocol**

The following are a set of questions using the miracle question as a part of supervision or consultation:

1. Have the worker share with you a problem that they might be having during a session or in sessions in general. Make sure that the worker is comfortable sharing with you or with a supervisory group. The idea is to explore possibilities not prescribe predetermined action or treatments. It is not looking at 'what is wrong' but what is possible. Once the worker has briefly shared the struggle he or she might be having or something he or she would like to change, clarify what has been shared by reflecting back and paraphrasing what the intent of the work will be, using key words of the worker when possible.
2. Now ask the following miracle question: Let's say that you finish work today and you go home and take care of what needs to be done and then you go to bed as usual. But, tonight will not be usual. Tonight a miracle is going to happen. The miracle is that the struggles or problem you are having in this situation will disappear. The problem will no longer exist. But, since you are sleeping you have no idea that the miracle has taken place. You get up and do whatever you do in the morning and come to the agency. You are still unaware of the miracle happening. Then you see or hear from the client with whom you have been having some difficulties. What would be the very first thing as the session gets started that would tell you that something is really different? What will be different about you and/or the client that will really surprise you? Things are going so well! A miracle must have happened! What is different?
3. Also, ask "What else?" as a way of finding other possible changes.

4. Now the worker has to describe in detail what he or she would be doing, thinking, and feeling when this change takes place. Remember this is a miracle and any idea is welcome.
5. Now, ask "What do you think the client is doing that helped to make things better?" How would you respond to the client when he or she acts like the miracle question described?" "What do you think you are doing that helped make things better?" And then, also remember to ask "What else?"
6. Explore with the worker how these changes made things better. Even if they focus on the client, ask the worker how this would change how he or she would respond differently to the client and how he or she is feeling differently toward the client now that the miracle has happened.
7. Now ask about exceptions. When were there times when the relationship and the work were similar in any way to this miracle? What was different? Get specific details of the client's actions and the actions of anyone else involved, including the worker and/or the agency. This is important because the negative experiences narrow the focus onto the client as the answer, rather than the context and mired of other possibilities. Remember, "What else?"
8. Get as detailed a description of the exception times and possible changes that might have alerted the exception times Then ask "What would it take to make have these exceptions or miracle take place?"

### Example of Solution-Focused consultation

This example has been taken from an actual group consultation or supervision. Recall that the workers and their supervisors are being trained to do more Solution-Focused direct work with families. Usually five to six workers participate, all of whom are social workers with MSW degrees. Although the focus is on one particular case, all members of the group are asked to participate in the miracle question and to make comments during the discussion. This adds to the pool of creative possibilities and aids in teaching solution-focused work and is built around collaborative relationships.

*Child Protective Service Worker [CPSW]:* I have a real problem. The mother came for a supervised visit here at the agency and she was crazy. She was yelling that she wasn't being allowed to see the kids without someone watching and that she was going to make sure they were OK in the foster home. There had actually been some problems in a previous fos-

ter home and the children had been moved. She was aggressive and demanding that she speak to her children about how they were doing in the foster home and she would question them about what was happening in the foster home. I tried to tell her that that was not appropriate. The children do not need to be questioned about everything. She is there to visit with them. We had to have the police officer come and help to get her to stop yelling. It was really something and I can't see those kids being returned anytime soon. I don't look forward to seeing her.

*Consultant:* That was obviously very hard on you and everyone else involved.

*CPSW:* Yes and I don't know what to do anymore. She is impossible. I can't get in touch with her most of the time. She doesn't respond to my phone calls. I have really had it with her. I can't see the kids ever going back with her [other members of the group were commenting about how difficult she was].

*Consultant:* I can imagine with all the cases you have and the hard work you do it is discouraging. All of you have a very hard job as we have talked about before. Let me ask you one of those strange questions we use sometimes, the miracle question. So, let's see if all of us can play out this miracle question. You go home and take care of what needs to be done and go to bed as usual. Then during the night a miracle happens and that miracle is that this mother is changed, just like that, into the person you would look forward to working with. Now when you awake, you get up and go to work as usual. Of course you do not know the miracle happened. What would be the first thing that you would notice when you find yourself involved with this mother that would tell you, "This has got to be some type of miracle, I can't believe how this is going!" What would be the first things that you would notice about yourself and about her that would make you think something really strange must have happened?

*CPSW:* She wouldn't be my client. [everyone laughs]. Seriously, that is hard to thinking about. I guess I would be looking forward to contacting her and meeting with her.

*Consultant:* What else would be different? What would be different about you and about her that would tell you that this had happened? Something is different?

*CPSW:* I guess she would be calm and wanting to work on getting her kids

back. I would be calm too, and be able to talk with her about what has to happen to assure safety.

*Consultant:* What would she be doing that would tell you that she wanted to work on getting her kids back?

*CPSW:* She would be respectful and calm with me and when seeing the kids she would not be grilling them about the foster home and how they were doing there. She would be just talking with them about stuff. I need to see that she is able to be responsible and committed to having the kids back. She would be responding to my calls and talking with me about what needs to happen.

*Consultant:* So, has there been any time when seeing her that it was in any way close to your miracle picture?

*CPSW:* I think at first before the kids were placed in foster care the first time she seemed more willing to talk with me and contact me.

*Consultant:* What was different about that time? What do you think made things different for her?

*CPSW:* Let me think. It has been so hard lately. I guess the situation was that until she made some changes the kids would be safe in the foster home and it was temporary.

*Consultant:* So, what did you do to help make things better at that time?

*CPSW:* I saw the move for the kids as temporary and that what we had agreed needed to be changed could be done more easily than how it has turned out.

*Consultant:* So, how do you think what you were doing and saying helped make things better for her at that time?

*CPSW:* I believe she heard me saying more positive things. She understood that foster care was temporary and the kids would be Ok until she made the changes. I was reassuring and hopeful that this case would work out by following the ideas and changes we had developed together.

*Consultant:* How do you think that was helpful for her? How did that help her stay calm and work more with you?

*CPSW:* I guess she felt more secure about the kids and getting back to normal.

*Consultant:* I can see how that might help her stay calmer and work with

you. What would it take to make that happen again?

*CPSW:* I don't know, because the kids did have a real problem in that foster home and we had to remove them and place them in another home. She was mad at what happened.

*Consultant:* So the fears she had took place. Given that situation, what did you think has changed for her?

*CPSW:* I guess she does not believe me about keeping the kids safe and it has been harder to talk with her because she is so mad at us for taking them and then having to move them again.

*Consultant:* So, what might you do to help her believe you again?

*CPSW:* I am not sure, she is so angry now.

Another CPSW in the meeting: Sounds like she's a mother grizzly bear.

*Consultant:* Tells us more about that. In what way is she a mother grizzly?

Other *CPSW:* Well like now she sees her cubs in danger and she is attacking us just like bears do when they have cubs.

*Consultant:* So, if that is happening, what does that say about this mother? What does it tell you about her?

*CPSW:* She is mad at the fact that we did not protect her kids well and had to move them to a new foster care home. She is trying to protect them like any mother would. She doesn't trust me or us anymore.

*Consultant:* That makes sense. What would you have to do to try to reach out to her when she thinks the agency does not see her as a good enough mother now and might not be protecting her children?

*CPSW:* I need to be able to tell her that I do know she cares very much for her children and their safety and she is a good mother in many ways. I guess her anger was like a bear and her cubs. She should not have done it that way, but I can see how she might be feeling now.

*Consultant:* So, given that she is refusing to see you, how might you let her know what you think about her as a mother and the possible fears with having had the kids being removed from the first foster home?

*CPSW:* I sometime write letters to clients. I could write her a letter letting her know that I know she really cares about her kids' safety and wants to have them with her. I can try to reassure her about her concerns giv-

en the last foster home situation. Also, that what we had worked on can still happen so that her kids can come back home.

*Consultant:* So, is it worth the effort to let her know that? Is that something you could do soon?

*CPSW:* Yes. I will meet with my supervisor and draft a letter to her.

*Consultant:* Obviously we have no idea how this might work or might not work in this case. But it seems like this might be a possible way of re-engaging her in the way you had originally engaged her. Let's see what happens.

[The mother actually showed up for a session with the worker and brought the letter with her. She was much more agreeable and had a good visit with her children.]

## Building on progress

In this example the workers (all members of the group) have learned to step out of the problem-saturated talk with increasing negative judgments being made about this client. They have found that by stepping back and looking at what the possibilities might be, rather than getting caught up in all that is wrong, they can begin to take other perspectives on the behaviours and find creative ways to engage the client. They can recognise what they might or might not be doing that is having an impact on the process and the work with the client without focusing on what went 'wrong' and staying with the negative stories about the client's behaviours. The focus is on the possibilities rather than the 'failures'.

This has made the sessions with workers an increasingly positive growth experience and positivity is always connected to creativity and thinking in a broader manner (Fredrickson, 2001). Rather than repeating the usual narrative exploring potential problems or deficits, the experience is building confidence and the ability to consider options and possibilities. The workers have been able to learn to do this on their own and self-reflect in a more productive manner. From my experience, solution-focused consultation (supervision) helps provide the opportunity for workers to step out of the narrow focus of the negative narrative or worse, the tendency to put more pressure on the client and become more critical. Instead they can demonstrate their creativity and the art of the work they do when constructing a narrative of possibilities and positive outcomes with families and their approach to them.

The follow-through in the next session is usually initiated by asking,

"What has been better?" meaning anything including the issue that was the focus of the previous session. Here the opportunity is to discover any other positive change as well as following through with how the new effort made a difference. This again maintains the positive expectation and potential for movement to having improved outcomes. Even if only small shifts have been noticed, these small shifts are first steps to better outcomes. The conversation can then become how to build on these. It has been suggested that we use scaling in our work and of course that is something we have started adding to supervision. It is used in the work between the worker and the client as part of their training as more active and engaged CPS workers.

## Conclusion

Solution-Focused work requires a very different perspective from what is usually a pathological view of the family needing to be treated or fixed by special services. The CPS system in the United States is in many ways an adversarial encounter, (although it is not considered to be by the agency and workers). In the United States, families are deemed problematic and then sent to various services which then are monitored by the CPS worker. The worker creates a plan of intervention and then expects the family to engage in psychotherapy, parenting classes, drug treatment or anger management classes. If the family members do not comply then pressure is put on them to participate. This position sets up an adversarial relationship and also encourages workers to look for the negative behaviours such as 'not attending' some intervention programme. Shifting from this 'adversarial' expert role to a strengths-based, Solution-Focused and collaborative case work role is not an easy change to make. The idea of protecting children overrides the opportunity to engage the family in the exceptions and potentials of Solution-Focused direct case work with the family to make changes and utilise services. The focus on what is going wrong, and identifying negative behaviours which are creating a safety issue for the children, are obviously significant as the focus of the work is to protect the child. Yet, the intention is to also enhance the function of the family and maintain the child with his or her family.

The constant repetition of problematic family situations over time can result in supervisors and workers becoming jaded and blind to what is possible. This is very difficult work and the worker is on the front line of a great deal of pressure and politics. Thus, it is very hard to shift away from the traditional role as 'overseer' of the family. In this role, the workers often take on a very narrow and negative perspective that results in worker frustration and negativity toward the families.

This research project and the work just described is an effort by this agency to make real changes in how child protective workers see families and work with them. This is the first real challenge for the workers learning Solution-Focused practice; to stay on the side of what works and what the possibilities or opportunities are that can be created when one is creative and learning to think in a broader context. Enhancing awareness through Solution-Focused practice by stepping back and looking at possibilities (no matter how farfetched they might seem to traditional practice) is one key to prevent falling back into dissecting negative problems and giving suggestions on what to do. It also helps focus the work on the efforts of the worker without taking a judgmental stance. Many times, these opportunities for creativity and imagination, like trying the miracle question, can help open workers and supervisors to see the situation anew and find other options and perspectives.

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# The Break (and Summary) in Solution-Focused Brief Therapy: Its Importance and Client Experiences\*

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The end-of-session break was nominated by Steve de Shazer as an essential component of Solution-Focused Brief Therapy; yet it is an aspect often ignored or eschewed by many Solution-Focused therapists. After reviewing the history and development of the break and the end-of-session message, this paper argues that the recency effect in cognitive psychology highlights the importance of how therapists conclude their sessions and that, if the way the session ends is important, perhaps it warrants some time to consider and plan. A qualitative study suggests that the break is not only useful to therapists but that clients report that the therapist taking a break and then providing a summary message enhances the benefit of the session for them. Limitations of the study are discussed and it is suggested that the findings contribute to discussion and ongoing evolution of the Solution-Focused approach.

Steve de Shazer, one of the founders of Solution-Focused Brief Therapy, and someone who claimed that he used the Miracle Question “almost always in the first therapy session” (de Shazer, 1999, p.1), is reported to have said, “If I was forced to make the choice ... I would give up the Miracle Question before I would give up taking the break!” That is quite a strong, and perhaps provocative, statement, particularly given that informal, anecdotal enquiry suggests

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that many therapists who describe themselves as Solution-Focused do not routinely take a break towards the end of their therapy sessions.

Thus, it might be useful to reconsider the importance of “the break” (and the subsequent end-of-session summary to the client) in Solution-Focused Brief Therapy and to ask what the experience of our clients is about the break.

## History and Development of The Break

One of the developments that characterised the early Family Therapy (and Brief Therapy) movement was the use of one-way mirrors and observing teams. Weakland, Fisch, Watzlawick, and Bodin (1974) write that the use of a one-way viewing screen was part of their practice from 1967, initially using a therapist and one observer and later preferring a team of observers behind the mirror. Minuchin (quoted by Lappin, 1988) explains that, as part of developing his family therapy approach, “We broke through a wall in our treatment room and put in a one-way mirror and began to observe one another ...” (p. 225). Taking a break began simply as part of doing therapy with a team and a one-way mirror. Pragmatically, the therapist needed to take a break in order to consult with the team behind the mirror so as to benefit from their observations.

As more strategic brief and family therapy approaches developed, the break and the team became part of the STRATEGY of therapy. In Strategic Family Therapy (Nichols & Schwartz, 2001; Papp, 1980) and MRI Brief Therapy (Weakland et al., 1974), the team, the break and “the intervention” were used to attempt to influence the client and/or interrupt a systemic pattern. Cade (1980) reported using “contrived team conflict” during the break as a way to break therapeutic impasses. Selvini Pallazoli and her colleagues saw the purpose of the “intersession break” was for the team to agree upon a comprehensive systemic hypothesis about the development and function of the symptom, leading to “the intervention” which usually offered the family this hypothesis as a systemic explanation of their predicament (Tomm, 1984).

Observation of therapy by a team and consultation with that team were essential parts of the early days of what was to become Solution-Focused Brief Therapy. Four of the original Milwaukee team remember that, initially, “The interviews were conducted in Steve and Insoo’s living room by one person while a team observed.” (Lipchik, Derks, Lacourt, & Nunnally, 2012, p.5). Lipchik and her colleagues recall that, “... after the mirror was installed ...”, consultations between the interviewer and the members of the team became commonplace.

In the seminal paper that first presented Solution-Focused Brief Therapy

in a systematic way (de Shazer et al., 1986), the authors describe the typical functioning of the Milwaukee team. "After 30 to 40 minutes the therapist excuses himself to consult with the team ... After an intermission of 10 minutes or less, the therapist returns and gives the formal intervention." (p. 216). The intervention (the "message from the team") was seen as the primary agent of change.

Lipchik and her colleagues comment that, later, as Solution-Focused Brief Therapy developed as a definable approach, "the interview rather than the intervention became the primary agent of change" (Lipchik et al., 2012, p.9). As will be shown below, the message given by the therapist after the break changed in nature but was still viewed as important. Thus, the break began to be seen primarily as a chance to think carefully and prepare the end-of-session message or summary. Consistent with this, it began to make sense to take a break to prepare the summary message even if the therapist did not have a team to consult. Cade (2001, p. 203) observed, "Solution-focused therapists typically take a break before ending each session, whether or not there is a team behind a one-way mirror with whom to consult."

Turnell and Hopwood (1994) suggest that the time before the break is where the therapist asks questions and listens, but the client talks. After the break, they suggest, the therapist talks and the client listens. They describe the typical therapist explanation as:

I like to take a break since you've said a lot that is very important and before I give you my [the team's] thoughts/some feedback, I want to spend a few minutes considering everything you have told me. (Turnell & Hopwood, 1994, p. 48)

In 1997, de Shazer and Berg, proposing a "research definition" of Solution-Focused Brief Therapy, posit four "characteristic features" of the approach. They nominate the Miracle Question and Scaling Questions as the first and second feature. The other two "characteristic features" are:

- (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).

That is, they saw the break and the subsequent feedback to the client as essential defining characteristics of Solution-Focused Brief Therapy. In their review of outcome research on Solution-Focused Brief Therapy, Gingerich

and Eisengart (2000) similarly nominate seven components necessary for classification as Solution-Focused Brief Therapy, including “(6) A consulting break, and (7) a message including compliments and task” (p. 479).

Ten years after de Shazer and Berg saw it as characteristic, the break is still seen as a normal and helpful part of the Solution-Focused therapy process. de Shazer and Dolan (2007) discuss taking a break as if it is still an expected part of the approach and again as an opportunity to think about what the client has said and frame the summary message. They assert that, even if there is not a team, “the therapist will still take a break to collect his or her thoughts, and then come up with compliments and ideas for possible experiments” (p. 11). De Jong and Berg (2008) similarly comment that, “When interviewing clients in a solution-focused manner, practitioners generally take a break of 5 to 10 minutes before giving clients feedback. This will have definite benefits for you and your clients” (p.115).

Eve Lipchik stressed the importance of taking a break in order to think carefully about what the therapist plans to say to the clients.

Those of us who are accustomed to taking breaks to formulate a closing message ... usually have stories to tell about the occasions we decided to forgo the break to save time. (Lipchik, 2002, p.100)

I would urge those therapists who feel uncomfortable about shortening their sessions to reconsider. The benefits clients get from a carefully designed summation message may well outweigh the extra 10 minutes of conversation. (Lipchik, 2002 p. 103)

Lipchik’s clear support for taking a break was based on her experience that a well-thought-out summary message is of benefit to clients and that a well-thought-out summary message requires some space to consider and plan it. Macdonald (2007) makes a similar point.

It is a common experience that appropriate responses occur to us just after we have left a situation ... It is in the nature of human interaction that we are affected by one another’s emotions [and] when clients are anxious and unable to reflect, we will be affected by this ... Leaving the room ... allows us the cognitive space to think more clearly about their situation and about what comments will be most useful.” (p. 25)

Macdonald comments that, if in a situation where taking a break is impractical, he simply asks the clients to wait while he takes a few moments to think about everything they have said. This suggestion accords with Ratner, George,

and Iveson (2012) referring to a “thinking pause”. They comment that many practitioners will take a break and that some will leave the room while others may pause but remain in the room. Thus, they seem to be retreating from de Shazer and Berg’s stance that taking the break is a distinguishing characteristic of the approach. Nonetheless, they still suggest that taking a break is pragmatically useful for the therapist purely as providing space to think.

## The End-of-session summary

In the early days of family therapy, particularly strategic family therapy, the interview was largely seen as a process of gathering information which would be synthesized by the team during the break and the therapist would then return to the room to “deliver the intervention” (Nichols & Schwartz, 2001; Papp, 1980). Haley (1993) described “strategic therapy ... as a name for the types of therapy where the therapist takes responsibility for directly influencing people” (p. 17) and said that the therapist has to design interventions to achieve those goals. Clearly, “the intervention” was viewed as the primary tool for achieving change.

Weakland and Fisch (2009) describe a process in which the therapist uses the end-of-session message to deliberately reframe behaviour, to instruct clients to do certain things and paradoxically to advise clients against making changes. In describing the operation of the MRI Brief Therapy Center, Weakland et al. (1974) discuss various aspects of the message (frequently “the message from the team”) that are specifically designed to influence behaviour. Watzlawick (2009) describes the MRI team’s interventions as “injunctions” or “prescriptions” and nominates direct behaviour prescriptions, paradoxical interventions (also called symptom prescription) and positive connotations as the three categories of intervention.

Given that Solution-Focused Brief Therapy was a direct descendant of the MRI Brief Therapy approach (Cade, 2001; de Shazer et al., 1986), it is not surprising that the prevailing view of the message delivered by the therapist following the break as being “the intervention” was carried forward. As noted earlier, de Shazer et al. (1986) describe that, following the break, “the therapist returns and gives the formal intervention.” (p. 216). The intervention (the “message from the team”) was still seen as the primary agent of change. Discussing the functioning of the team behind the one-way mirror, de Shazer and Molnar (1984) emphasise the planned, directive and strategic nature of the intervention, “the intervention delivered after the consulting break are usually phrased in terms of ‘we ...’ rather than ‘I.’” (p. 297).

de Shazer and Berg (1997) write that “the task” will often be framed as “an

experiment” and it seems that “experiment” may sound more benign than “task”. However, it is interesting that, before the name Solution-Focused Brief Therapy had been coined, de Shazer (1974) wrote about “interventions” and suggested, “Particularly useful is a kind of cross between paradoxical intervention and role-playing that might be called an ‘experiment.’” (p.22). As late as 2007, the founders of the approach and their colleagues (de Shazer & Dolan, 2007) still use the terms “experiments” and “homework assignments” apparently interchangeably. The term “homework assignment” seems to carry the connotation of a prescription.

Thus, the therapist’s message following the break was initially seen quite instrumentally as an intervention. However, there was some indication from early in the development of the approach that some of the emphasis in thinking about the intervention was changing. Lipchik et al. (2012) report that the intervention message in early Solution-Focused Brief Therapy, but also in the Brief Family Therapy that preceded it, always began with compliments to the clients. They suggest that the use of compliments was probably a reflection of the influence of the Milan group’s “positive connotation” (Palazzoli, Boscolo, Cecchin, & Prata, 1980); however, they note that it moved beyond that to a recognition that complimenting clients for what they had achieved encouraged cooperation and made it more likely that clients would return.

As mentioned above, in their delineation of the “defining characteristics” of Solution-Focused Brief Therapy, de Shazer and Berg (1997) specify that “the therapist will give the client some compliments” (p. 123). Campbell, Elder, Gallagher, Simon, and Taylor (1999) write extensively about crafting compliments to include in the end-of-session message. Ratner et al. (2012) see the major purpose of the message as building a clear expectation of beneficial change and that this is done by reminding the client about “qualities and capacities the client brings to his life that could be the basis of progress ... and actions the client has taken in the direction of the ‘best hopes.’” (p. 142).

de Shazer and Berg (1997) specify that the end-of-session message (following the break) will include compliments, followed by a task, or “experiment”. Tasks are still seen as something the therapist designs or prescribes. The use of the language “homework assignment” clearly reflects this view and, as mentioned above, as late as 2007 this nomenclature is still current (de Shazer & Dolan, 2007).

However, there are hints of something different much earlier. As early as 1984, de Shazer and Molnar (1984) describe what was then called the “Formula First-Session Task”,

Between now and next time we meet, we (I) want you to observe, so

that you can tell us (me) next time, what happens in your (life, marriage, family, or relationship) that you want to continue to have happen.” (p. 298)

All of a sudden, the task was NOT the therapist prescribing behaviour but was asking clients to notice particular (already existing) positive behaviour. Lipchik et al. (2012) comment that, as the work of the Milwaukee team became more obviously Solution-Focused, there was more emphasis on what clients were doing that was working and the message from the team became “designed to reinforce the strengths and resources of clients discovered during the interview, as well as to stimulate more options for solutions between sessions” (p. 9). Lipchik (2002) comments specifically that the terms “intervention” and “task” seem incongruous with the cooperative stance of Solution-Focused Brief Therapy. She deliberately uses the terms “Summation message” and “suggestion”, emphasizing that the summary allows clients to feel that they have been heard.

There seems to be some ongoing tension between those who see the task as instrumental and those who see it as primarily observational.

Macdonald (2007) talks explicitly about suggesting a task and his list of possible tasks includes “keep doing what’s working”, “do something different”, a prediction task and a “pretend the miracle has happened” task. He goes further saying that sometimes a therapist might suggest the client carry out a specific piece of behaviour — either one that emerged from the client or one that occurs to the therapist (although he acknowledges that clients rarely act on the latter kind of suggestion!). He adds that such more direct suggestions may helpfully be framed as “an experiment”. On the other hand, Ratner et al. (2012), who also prefer the term “suggestion”, suggest that simple “noticing suggestions” are now most common.

## **The Primacy-Recency effect**

This concept was originally observed by German psychologist, Hermann Ebbinghaus, in his 1913 experiments on memory (Crowder, 1976). When asked to recall a list of items in any order (free recall), people tend to begin their recall with the end of the list, recalling those items best (the recency effect). This is intuitively not surprising. However, this research shows that the NEXT most likely items to be recalled are the first few items. These are recalled more frequently than the middle items (the primacy effect). Put simply, if you are presented (verbally) a number of items, you are most likely to remember the last four or five items, and you are NEXT most likely to remember the first



four or five items.

More recently, the phenomena of primacy and recency have been confirmed by psychologists exploring persuasion — the things a person hears LAST, then FIRST, are more likely to have an ongoing persuasive effect. Costabile and Klein (2005) demonstrated that evidence and arguments presented towards the end of a trial were more likely to be recalled by jurors and so were more likely to influence their decisions and Y. Li and Epley (2009) showed that items seen towards the end of a presentation were more likely to be recalled favourably. Panagopoulos (2011) demonstrated that the messages presented in the closing stages of a political campaign are more persuasive, but also that messages from the beginning of the campaign retain more persuasive value than those in the middle. C. Li (2010) found a significant primacy effect in examining the recall and impact of television commercials aired towards the beginning of a program and those aired towards the end.

The primacy and recency research suggests two things: how therapy begins is important and how therapy ends is important. The final few minutes of a therapy session are more likely to retain some impact (simply — they are more likely to be what the client remembers!). Therefore, if therapists want to make the most of this impact, it makes sense that they should devote some time and thought to what they are going to say at the end.

Taking a break and physically leaving the room punctuates the final five minutes or so of the session (Turnell & Hopwood, 1994). It becomes a discrete “phase” of the conversation and so is more likely to have greater impact on the client.

## **Survey of client’s experience of the break and summary**

The first author routinely takes a break towards the end of all her therapy sessions despite never working with a one-way mirror or a team. She finds it helpful to have the opportunity to reflect on what clients have said during the session and to have some space to plan her end-of-session summary message. Her end-of-session summary messages, following Lipchik (2002), simply consist of compliments “designed to reinforce the strengths and resources of clients discovered during the interview.” (Lipchik, 2002 p. 9) and are frequently followed by a suggestion that the client “notice between this session and the next whatever it is that they do that moves them one step up the scale” (Cade, 2001, p. 205).

Her impression is that her summary messages are more comprehensive and seem more powerful because of the opportunity to stop and think. “No longer do I have the experience that they are half-way out the door and I sud-

denly think, 'Oh ... I should have said ...!'. However, the question remains of how clients view their therapist leaving them for eight- to ten-minutes near the end of each session and then returning to give a summary and suggestion.

Therefore, the research question for this study was: How helpful do clients find the end-of-session break and the subsequent summary message in Solution-Focused Brief Therapy sessions and how do they describe its usefulness?

The participants in this primarily qualitative exploration were 33 adult clients attending therapy in a suburban area in Australia. This service is a "generalist adult counselling service" with clients referred by medical practitioners, community organisations and self-referral. Clients were approximately two-thirds women, between 20 and 50 years of age, and presenting with a range of concerns including depression, anxiety, post-natal depression, difficulty managing their children, relationship concerns, bereavement and effects of trauma.

Participants were recruited using non-random convenience sampling (Marshall, 1996). Every client who attended a third session during the period of data collection was asked if she or he would be willing to answer a brief question at the end of the session. The third session was chosen deliberately. The rationale for this choice was that, by the end of the third session, clients would have had three experiences of sessions in which the therapist took a break and returned to give a summary message. Therefore, it was assumed that they would have become "used to it" and would not be commenting purely on something they had experienced as novel.

Further, Solution-Focused therapists' experience is that the whole course of therapy tends to be brief. Iveson (2002) nominates three to five sessions as typical and Gingerich and Eisengart (2000) describe "usual" as fewer than six sessions. Thus, collecting this data at the end of the third session meant the study was less likely to miss contributions from any clients who terminated therapy after only a few sessions.

In fact, no client ended therapy prior to the third session during the period of data collection. No client refused the request to participate.

At the end of the third session, clients were asked,

Is it okay if I ask you something as part of some research I am doing?  
(If they said "yes") You remember that, each time we have met, I have taken a short break towards the end of our session, thought about what you'd said to me and then come back and shared some ideas with you. You know that I find it helpful to take that break; however, I'm wondering how helpful my taking that break has been FOR YOU. So, on a scale of 0 to 10, where zero is "Not at all" and 10 is "Extremely

helpful”, how helpful TO YOU has it been that I have taken a break towards the end of each of our sessions?

Clients’ responses between 0 and 10 were recorded. The initial numerical (scale) responses were simply averaged. While not a stringent statistical test, this provided an indication of the strength of subjective perception underlying the subsequent qualitative data.

Then clients were asked, “So, what was it about my taking the break that makes it x on the scale (whatever number the client had said)? What has been helpful for you about me taking a break?”

Client responses were recorded verbatim, but without identifying data, then a qualitative analysis of predominant themes was performed. The procedure described by Braun and Clarke (2006) for “thematic analysis” was adopted to analyse the data. Initial coding of the data was conducted, using an inductive process which sought to generate codes from the data itself rather than from any preconceived theory or system. Coding produced an initial list of tentative themes, which were then reduced through grouping. Braun and Clarke (2006) describe “thematic analysis” as a flexible approach that is “a relatively easy and quick method ... to do” (p. 97). Given that this study had quite a limited research question and that the data from each respondent was only a few sentences, a more exhaustive qualitative analysis approach was not considered necessary. Nonetheless, “thematic analysis” provided a way of analysing the responses in a systematic manner.

## **Results**

### **A. Numerical scale**

In answer to the question, “How helpful TO YOU has it been that I have taken a break towards the end of each of our sessions?”, using a Likert-type 0–10 scale, the responses ranged between 5 and 10. The mean of the 33 responses was 8.6 and the mode was 10. In fact, one third of all respondents (11 out of 33) rated the usefulness to them of the therapist taking a break as being 10. The frequencies of the various responses are shown in Figure 1.

### **B. Qualitative data**

Following the initial inductive process of identifying themes in the data and then combining or grouping these where it seemed they overlapped, six themes emerged for describing clients’ experience of the helpfulness of the break and the ensuing summary.

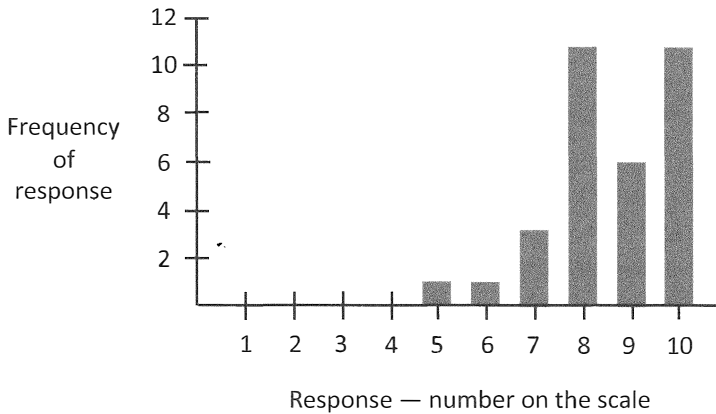


FIGURE 1. Frequency of each response to scaling question

### 1. The break has personal, practical benefit to the client (14 respondents)

A number of clients commented first on some personal, practical benefit of the break in the therapy process. Most frequent (11 respondents) was some appreciation of the opportunity to pause, clear their head and enjoy quiet.

- ◆ *"It gives me time to check Facebook and check for messages".*
- ◆ *"When I've been emotional during the session, the break enables me to take a breath and collect myself".*
- ◆ *"The break gives me a chance to clear my head. I go outside and have a smoke".*
- ◆ *"I like having a moment without interruption at the end which lets me feel, have some space and collect my thoughts".*

### 2. The break and summary allow the client to think/reflect (14 respondents)

The therapist often explains the break to clients by saying something like, "... I will take a break and think about what we have talked about ..." (Korman, 2004). In this survey, a number of clients replied that the break offered them an opportunity to think about the session as well.

- ◆ *"I like that it also means that we as clients can reflect about what we've said in the session".*
- ◆ *"I like the summary because it makes me think about what I said in the session".*

- ◆ *"My husband and I were able to use that time to reflect together on what we'd said during the session".*

### **3. The summary helps the client feel affirmed (12 respondents)**

A number of clients commented on the "positive" summaries and how they "felt good". There was also a sense that the compliments confirmed for the client that she/he was already heading in the right direction.

- ◆ *"It's nice to hear someone say the positive things and affirm that I'm on the right track."*
- ◆ *"The positive comments in the summary forces me to reflect on things in a different way."*
- ◆ *"It affirms what I think or where I need to go from here."*
- ◆ *"You're good at saying what I did well."*
- ◆ *"I like that you reflect back what I maybe did not realise myself."*
- ◆ *"It makes me feel that I'm coping better than what I had thought."*

### **4. The break increases the client's confidence in therapy (6 respondents)**

There was a strong sense that the therapist "bothering" to take a break and think indicated to the client that the therapist was serious or was taking the client seriously. Rather than thinking that the therapist leaving the room for a "think break" was idiosyncratic or strange, clients felt affirmed in the knowledge that the therapist was actually taking time to think about what they had said.

- ◆ *"I prefer this to my previous psychologist who did not take breaks and it made me feel that he gave less thought to the session or what I wanted or needed."*
- ◆ *"You taking a break and then giving the summary makes me feel that the counselling is going somewhere".*
- ◆ *"The break and the summary make me feel that you have really thought about what I said".*

### **5. The break enhances the client's experience of the summary (5 respondents)**

A number of clients reported that the break made them more focused on the

summary that was to come.

- ◆ *"You taking the break, makes me more focused on the summary afterwards and that it gives me food for thought "*
- ◆ *"Having had the break helps me to think more about what you say when you come back ."*
- ◆ *"The break makes me consider what this all means and reflect on what you may be going to say during the summary."*

## 6. The break and summary help extend impact of therapy (4 respondents)

Perhaps related to the idea that the break enhances the client's expectation of the end-of-session summary is the observation from a number of clients that the break and summary gave them something to take away.

- ◆ *"It makes it easier for me to remember the session and to be able to tell my husband about it and that helps us to talk about it at home."*
- ◆ *"You having taken the break and then giving a summary makes me feel that I take something away from the session."*
- ◆ *"When you cement things through the summary, it makes me continue to reflect on things in the car on the way home".*

## Discussion

As mentioned above, anecdotal experience suggests that many (if not most) Solution-Focused therapists do not regularly take an end-of-session break. So, for example, Iveson describes himself as "someone who deliberately doesn't take a break (unless there are other people watching the session)"<sup>1</sup>. However, this research suggests that clients almost overwhelmingly describe the therapist taking a break and then returning to give the end-of-session summary as positive and helpful.

As well as mentioning practical benefits (calming down, checking messages, etc.), a number of respondents commented on the usefulness of the break providing them with an opportunity to think and reflect. This supports Cade's (2001, p. 204) suggestion that "A break also gives the client time to think about the session ... Also, clients often come to therapy expecting to be probed and exposed in areas of their greatest doubts or emotional sensitivity

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1. Comment on the Solution-Focused Therapy internet discussion list, FT-L@LISTSERV.ICORS.ORG, 30 September 2011.

and/or to be ‘told the error of their ways’. The break brings the realisation that this is not about to happen.”

Compliments have been seen as a central aspect of the end-of-session message in Solution-Focused Brief Therapy (Campbell et al., 1999; de Shazer, 1988). Compliments are reflections from the therapist (or from the team) of strengths, resources, exceptions, and “things I can see you are already doing to move towards [your preferred solution]”. That many clients commented that the end-of-session summary (based on compliments) helps them feel affirmed is perhaps not surprising. However, the frequent comments of clients about feeling heard or feeling valued simply by the experience of their therapist taking a break are illuminating. Believing that the therapist was taking them seriously and then feeling validated that they were already on the right track together seem to enhance the client’s positive view about the whole therapy process.

Cade (2001) suggests that the break “heightens [the client’s] sense of anticipation about what the therapist’s (and, where relevant, the team’s) opinion and suggestion is going to be”. This was confirmed by respondents who mentioned the break enhancing their experience of the summary.

It was suggested earlier that Ebbinghaus’ concept of the recency effect (Crowder, 1976) might help explain the impact of the break and end-of-session summary. The very fact that the summary message is the last thing clients experience means it is most likely to be recalled. Those respondents who mentioned their experience that the message helped them reflect further after the session seem to support this. It might be argued that the move away from prescriptive tasks means that clients are not required to remember detailed instructions and so that improved recall explained by the recency effect is not relevant. However, if our end-of-session message reminds clients of successes and strengths they have already shown, then it could be argued that there is some benefit in their remembering this later. Further, broader research on the recency effect suggests that it is not just recall that is enhanced but also that those things presented last are more likely to have greater impact (Panagopoulos, 2011). In reality, the impact of the message is probably explained by a combination of factors (including those revealed by the themes that emerged from responses); nonetheless, the recency effect is offered here as a reminder that the way we end our sessions matters.

## **Limitations and further debate**

This qualitative study canvassed views from clients of only one therapist and that therapist conducted the survey and collected the data. Thus, the possi-

bility that clients' ratings of the break and summary might have been inflated by their overall positive experience of this particular therapist cannot be discounted. A larger study, surveying clients from a number of therapists and with the data collected by independent researchers, would be required in order to remove this potentially confounding factor. Related to this is the question of generalisability and it might be argued that the results of a small study are not able to be generalised. Myers (2000) observes that a frequent criticism of qualitative research is that its reliance on small samples makes generalisation impossible. However, she asserts that generalisability (in terms of probabilities) is not a goal of qualitative research. Horsburgh (2003) suggests that qualitative research aims to add to understanding of a (subjective) phenomenon and that results may offer suggestions for understanding similar phenomena in other contexts.

These findings that clients experience the break and summary as helpful and positive do not, of course, imply that therapists who, for whatever reason, do not take a break are giving their clients a negative experience. Knutsson, Norrsell, Johansson, Öhman, and Ericson (1998), in an evaluation of their clinic in Sweden, report that some clients appreciated the break as a chance to reflect and all their clients experienced the message as positive (however, they do not explore that further). In contrast, (Henfrey, 2010) reports that clients who had reported improvement following Solution-Focused Brief Therapy largely did not endorse the statement, "the therapist taking a break towards the end of the session was useful to me" (p. 30). Shennan and Iveson (2012) report that this latter finding prompted them to discontinue taking a break in their sessions.

In 1997, de Shazer and Berg named taking a break as one of only four defining characteristics of the approach. Almost twenty years later, it is clear that the approach has evolved (and is evolving), with different practitioners having different emphases. In the present study, the specificity of clients' accounts of how they found the break and the summary helpful offer some insight into how they experience a particular aspect of Solution-Focused Brief Therapy in one particular place. What matters is not that this understanding can be generalised to all other practitioners of the approach. Rather, our hope is that this understanding both allows us to be more mindful about what we actually do and also contributes to ongoing discussion within the community of Solution-Focused practitioners as the approach continues to evolve.

Korman (personal communication, 2011) recounts an experience where a client commented, "I've seen lots of psychiatrists and therapists before, but none of them have really cared about me the way you do!" When asked what gave her this impression, the client replied, "None of them took a break to



think about what I had said!”

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## **A Personal View — Solution-Focused Therapy: The Research and the Literature. Where Do We Go From Here?**

**Alasdair Macdonald**

After a brief reflection on the development of psychotherapy up to the present day, I summarise the current evidence base for Solution-Focused Brief Therapy (SFBT) and Solution-Focused approaches to organisational process (130 published outcome studies). Becoming familiar with the literature has changed over the last 50 years. It is no longer a matter of chatting to colleagues in your own field. New projects are published in many countries and languages. The database is now extensive and we need to develop strategies and systems which will enable us to keep pace with the expanding area of knowledge. How may this be done?

### **The treatment of mental disorder through history**

The Moors developed maristans for the mentally ill: the earliest to be identified as primarily psychiatric was founded in Cairo in 872. Mediaeval laws in England allowed for mental disorder. Courts would rule on whether someone was 'mute of malady' or 'mute of malice'. Relatives cared for those with maladies. If a mentally ill person had no relatives their estate fell to the King, which may have served to encourage community care by relatives.

In Elizabethan England there were several slang terms for beggars who were feigning mental illness, suggesting that both real and feigned mental illness was recognised. In eighteenth century London, lunatics were confined

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in Bedlam and similar institutions. The public would visit them for a fee and mock their afflictions.

The Russian scientist Pavlov began his work in the late nineteenth century. He demonstrated stimulus-response conditioning in dogs. This is usually summarised thus: ringing a bell when food was presented led to salivation when the bell was rung in the absence of food. However, Pavlov's own writings are a model of scientific clarity and reveal more complex material. Writing in the Russian language he talked of 'conditional' reflexes, that is, reflexes which occurred in a certain context. In translation this became 'conditioned' reflexes, implying that the reflexes were induced or inserted by the experimenter. This moved the focus of interest towards control by the experimenter and away from the innate abilities of the animal and from the context in which the reflexes were induced. This led behaviourism to be interpreted as a form of didactic process and less attention was given to the responses of the subject of the experiments.

Freud and his circle developed the concept of the mind as a dynamic organ in which thoughts and feelings were coloured by previous experiences. Many of their ideas are foreshadowed in the writings of Dickens and Henry James. Treatment by psychoanalysis would last about six months and might well be delivered to friends or family. At the same time, Binet in 1905 Paris was developing the measurement of intelligence in school children by the use of tests.

Freudian ideas came into use in the UK for use with cases of 'shell shock'. Up to the First World War a medical degree was an essential preliminary to a psychoanalytic training. Rivers, working in Craiglockhart House in Edinburgh, wrote in *The Lancet* (1917) about his methods. Literary figures treated by Rivers (Siegfried Sassoon, Wilfred Owen) did much to spread the popularity of psychoanalytic ideas among artistic and creative people. Research into its effectiveness was only begun in the 1950s.

In the Second World War, there were not enough trained practitioners available for the number of psychological casualties. Hence group treatments were studied in detail. In any case, the Army expects everyone to do things in groups, so this encouraged such developments.

Post 1950, the medical insurance system in the USA agreed that psychological treatments for veterans would qualify for payments. There was an upsurge in spending and in facilities as a result. In the UK, mental health care was much improved by its inclusion in the NHS. Previous care by local authorities had been generally well-intentioned but fragmented and under-researched.

In the 1960s, psychologists limited themselves to offering intelligence and personality tests only. By the 1970s, psychologists had begun to deliver behavioural therapies, with the addition later of other models of therapy.

Psychodynamic therapies remained within psychiatry, although practised by many psychologists also. The first outcome studies in the psychotherapies were published at this time. In the later 1970s, family therapy, systems theory and organisational work were the subject of rapid development. The Mental Research Institute in Palo Alto, California developed strategic therapy, looking at the client's understanding and language instead of the therapist's assumptions. This led to the development of SFBT in Milwaukee in the late 1980s.

From 1980–2010, there was a major expansion of counselling and psychotherapy services in public and private sectors throughout the Western world. Psychiatry in the UK linked with cognitive-behavioural therapy, although psychodynamic therapists remained a mainstream profession. Psychiatry in the USA used psychodynamic ideas, with other therapies mainly carried out by psychologists.

The expansion of psychotherapy in the UK has been countered by the Improving Access to Psychological Therapies (IAPT) initiative from central government. This emphasises relatively untested brief CBT methods. Currently an overall 30% success rate is demonstrated against a goal of 50%. This new programme has led to deskilling or privatisation of other therapists and services such as drug and alcohol programmes. Managers assume that all therapy will now be short-term or time-limited, mostly being carried out by relatively junior health workers. A similar programme in Sweden has visibly failed and been withdrawn in 2013. Lack of choice, inadequate training and a failure to grasp the multifarious nature of mental distress seem to have been among the difficulties encountered.

As psychotherapy research has advanced world-wide, we begin to recognise that common factors play a big part in outcome. Choice and control for the client, therapist allegiance, the client's opinion of the therapeutic alliance and the client's abilities all make a contribution.

## Studies of outcome at the present date

When I became the research coordinator of the European Brief Therapy Association in 1994 there were eight outcome studies in two languages. This seemed manageable to me.

The second edition of my textbook (Macdonald, 2011) reviews the outcome research in Solution-Focused work up to 2010 so I will not repeat that here. Publication has greatly accelerated since then. In the last two years Google Scholar has identified over 1600 publications annually in many languages. Franklin et al (2011) describes the current research scene.

Currently we find 128 relevant studies: 2 meta-analyses; 26 randomised controlled trials showing benefit from Solution-Focused approaches with 13 showing benefit over existing treatments. Of 47 comparison studies, 38 favour SFBT. Effectiveness data are also available from some 5000 cases with a success rate exceeding 60%; requiring an average of 3–5 sessions of therapy time. Details of each publication may be found in the evaluation list on my website ([www.solutionsdoc.co.uk](http://www.solutionsdoc.co.uk)).

There have been 19 important studies since 2010.

### **Systematic reviews:**

- Lovelock et al (2011). Australia: Evidence-based literature review. SFBT shows Level II effectiveness for depression, anxiety and substance misuse.
- Bond et al (2013) UK: 38 studies included. Provides tentative support for the use of SFBT; particularly effective as an early intervention when presenting problems are not severe.
- Gingerich & Peterson (2013) USA: All available controlled outcome studies: 43 studies: 74% of the studies reported significant positive benefit from SFBT; 23% reported positive trends. 3 studies: SFBT used fewer sessions than alternative therapies. They conclude that SFBT is an effective treatment for a wide variety of behavioural and psychological outcomes; may be briefer and less costly.

### **Randomised controlled trials:**

There have been eight randomised controlled trials from five countries. Randomised controlled trials are the benchmark for studies of new drugs in medicine. They may not be the best form for trials of psychotherapy.

- Iran: Amiri et al (2013): useful improvement in nurse communication (71 subjects).
- Iran: Babollah et al (2011): behaviour improved in elementary and high school students (32 subjects).
- Iran: Javanmini et al (2013): depression in teenage girls improved (20 subjects).
- Iran: Saffarpour et al (2013): adjustment in female college students (60 subjects).
- Australia: Grant (2012): Solution-Focused coaching more effective than problem focused coaching in several domains (225 coaches).
- Chile: Schade et al (2011): Solution-Focused family work effective in somatoform disorders (256 subjects).

- Netherlands: Vogelaar et al (2011): reduced fatigue and medical costs in Crohn's disease (29 subjects).

A major study from Finland has just reached its final stages: Knekt et al (numerous publications up to 2013): 326 cases; 7 year follow-up. The main findings were as follows:

- A reduction in psychiatric symptoms and improvement in work ability and functional capacity in all treatment groups.
- The short-term therapies were more effective than long-term psychotherapy during the first year, whereas the long-term therapy was more effective later.
- No differences were observed between long- and short-term therapies during the last 4 years of follow-up.
- Additional treatment was sought by 80% in short-term therapy groups and 60% in long-term therapy group.
- Psychoanalysis was the most effective at 5-year follow-up.
- Cost-efficiency analysis including social and unemployment costs showed that long-term therapy cost three times as much.

### Comparison studies:

There have been six comparison studies in four countries:

- USA: Antle et al (2012): 4559 cases; high levels of fidelity to Solution Based Casework Practice Model demonstrated significantly better outcomes in federal child safety.
- Bulgaria: Bostandzhiev and Bozhkova (2011): Mental health day centre; 96 patients, many diagnoses including schizophrenia. 65.8% improved when SFBT included vs 20% without.
- Lithuania: Cepukienė and Pakrošnis (2011): 92 adolescents in foster care. 31% of the treatment group showed significant behaviour change.
- Lithuania: Pakrošnis and Cepukienė (2011 and before) : 112 adolescents: Significant improvement in 77% in foster care; 67% in mental health care and 52% in rehabilitation group.
- Bulgaria: Panayotov et al (2011): compliance / adherence with medication by patients suffering from schizophrenia. Fifty-one patients; treatment as usual then SFBT added. Own controls: compliance increased from 244 days to 827 days.
- Netherlands: Roeden et al (2012): 20 people with mild learning disability. At six weeks follow-up improvements in psychological functioning, social functioning, and maladaptive behaviour were statistically significant.



## Naturalistic studies of practice:

Four studies from three countries:

- USA: Bell et al (2011): Solution-Focused Guided Imagery as an Intervention for Golfers with the Yips. Four golfers; followed up for 12-14 weeks: effect maintained. The authors suggest that there may be useful effects on other task-specific focal hand dystonias such as musicians and tennis players. Note for management consultants: improving the Chief Executive's golf is likely to be a good selling point.
- Belgium: Hendrick (2011): 30 alcohol users: significant improvement at 1 year: 11.93 units/day reduce to 7.76.
- Belgium: Opperman (2011): 30 alcohol users; 63.3% drinking less at 1 year and in better physical health.
- Netherlands: Roeden et al (2011): 10 with mild intellectual disabilities: improved on quality of life, less maladaptive behaviour and more goal attainment.

There are also 11 studies in Mandarin, Korean, Indonesian or Farsi which I have not read.

## The story so far

In the 1960s, researchers knew each other and worked mostly within their own countries and languages. I remember a medical colleague who published a study without checking for other similar work. It turned out that he had duplicated other work. He was deeply embarrassed and was told he should not have published. Nowadays we believe nothing unless a study has been replicated, because many factors influence publication, including researcher allegiance and business consequences.

By the 1970s, studying a new topic often began with literature searches with the help of the university library. In the 1980s academics knew their field in detail. Searching would begin by consulting eminent authority.

Then online searches became feasible. For a while, this made literature searches very easy and no university connection was needed. However, Google now finds massive numbers annually, sometimes costing \$30 each for full access. Language groups: Google Scholar will find English, German and Korean. Others may be retrieved if Solution-Focused is mentioned in English e.g. in the abstract. Spanish articles are not all retrieved although it is the second most spoken language in the world. Political issues mean that Google is not widely available in mainland China and does not index articles in Mandarin or Cantonese. For researchers, English is still favoured for publications if you want to be an international star. However, publication in your local lan-

guage is good for your CV and therefore for your job prospects.

It has been suggested that we use meta-analyses and reviews only. But this adds a filter between reader and researcher. And does not solve the language problem. Most meta-analyses rely on randomised trials: is this appropriate for therapy? We know that client choice and therapist allegiance are relevant to outcome. Also therapy is not blind, and needs to have some connection with how the client views the problem. What about those who have two therapies at once or in succession (not unknown) or therapeutic advice from well-meaning friends?

The National Institute for Health and Clinical Excellence (NICE) in the UK draws up guidelines regularly. However, these are usually based on diagnostic categories, which is not an effective way of tracing Solution-Focused publications, since we pay little attention to diagnostic categories. Guideline committees usually only include two clinicians, so 'expert knowledge of the field' is also limited.

In 2012, at least 100 research studies were not in English (including over 60 from Taiwan alone) and others in Farsi, Finnish, French, German, Mandarin, Korean and Turkish. So the evaluation list that I compile confirms the value of the model but is no longer sufficient in itself. How to retrieve these many other resources? How to read them all? I can read three languages and have colleagues who speak Dutch and Mandarin. But everyone is busy! The vocabulary of Google Translate is not equal to scientific papers.

Now many queries come from new enthusiasts, some of whom do not seem to use search engines. So are we back to 'colleagues' knowledge? How can we address this mounting database? We do need to know about each other's discoveries. In 1970 one method was to find a paper on your topic, and then use the reference list at the end of the paper to find other relevant papers. Eventually this process would start to return papers that you had already considered, so the search might be considered complete. Maybe we need to return to this personal style of searching, using Google and other search engines to look for the papers that we have already identified.

The attenders at the University of Hertfordshire SFCT conference were asked to discuss these questions in small groups: Suppose that research into SFBT in Korea has produced absolute proof that it is useful to the population with whom you work. Think or discuss in small groups for a few minutes: How will you clarify the effect of this finding? Can you read the original work? Who else in Korea has published on this topic?

A number of suggestions were generated: develop an international hub to collate research; use language students as translators; interview the first author of any paper by email; adopt a standard format for publications,

including a structured abstract in English.

Psychoanalytic ideas were largely spread by the literary establishment. To spread knowledge of the Solution-Focused approach, suggestions included formalising and extending the use of social media; asking playwrights, TV drama and movie makers to include a brief reference to the topic; constructing a single sentence encapsulating the approach and including it in all possible materials (a technique devised by Robert Townsend for the Avis car rental organisation (1970)).

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## About the author

Alasdair Macdonald has been a consultant psychiatrist in the United Kingdom for 30 years with experience in work with offenders and is a former Medical Director. He is a registered family therapist and supervisor who has written two textbooks and published original work about psychotherapy outcome and other interests and is Past President of the European Brief Therapy Association. Alasdair is now a freelance SFBT trainer.

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## Emeritus Professor Wally Gingerich

**Interviewed by Alasdair Macdonald**

Dr Wallace Gingerich (known to all as Wally) was one of the original team members and founders of Solution-Focused Brief Therapy at the Brief Family Therapy Centre (BFTC) in Milwaukee, Wisconsin, USA and he was one of the authors of the first publication to clearly and systematically elucidate Solution-Focused Brief Therapy (de Shazer et. al., 1986). Alasdair Macdonald interviewed Wally in September 2013.

### **What first brought Steve and BFTC to your notice?**

It was 1982. I had been teaching social work practice courses at the University of Wisconsin-Milwaukee for some time and was looking for a setting where I could get back into practice myself. I was interested in BFTC because of their training program which included weekly seminars and live supervision of work with real cases. It could be a guided and protected environment for getting back into the swing of things.

I was not initially attracted to BFTC because of their approach. In fact, I didn't know much about it at the time other than their reputation in the community which was that they were an innovative, unconventional and even radical group and in the minds of many in the practice community pretty far out. Conversely, I was attracted to BFTC because it was a place where I could get back into practice, even though I was a little suspicious about their approach.

Steve and Insoo, on the other hand, were worried about what I might be up to, whether "this guy from the university was trying to infiltrate us to find out what we do and cause trouble." On the other hand Steve was interested in me because of my research background, and eventually they agreed to take me on even though they were a little suspicious of my motives.

### **What were you doing in your own work at that time?**

As I mentioned earlier, I wasn't actually doing any clinical work at the time. However, my previous experience in the mental health field persuaded me that direct, practical approaches such as Reality Therapy had much to offer, and during my doctoral studies I became very interested in behavioural approaches.

### **How and when did you join the team?**

I joined BFTC as a trainee in the Fall of 1982. By the spring of 1983, Michele Weiner-Davis (another trainee) and Steve and I had begun meeting informally in what we loosely called a research group and we decided to continue meeting on Tuesday afternoons beyond the conclusion of the trainee program to continue our clinical work but with a focus on research. Our little research group continued on for at least 4 or 5 years, as I recall, and several of our projects had a significant impact on the development of the Solution-Focused approach.

### **Where did referrals come from? Did the team seek clients actively (advertising?)?**

Many clients were self-referrals who found the clinic in the Yellow Pages, and a good number of them selected BFTC because "brief" was in the name. A few clients came because they had heard of the success of the clinic. Some clients were referred by clinicians in the community who respected the work of the BFTC team. Increasingly, clinicians would bring their difficult cases over for consultations with one member of the team and would observe from behind the mirror during the consultation interview to get some fresh ideas. Although the clinic had affiliations with health care plans and insurance companies on several occasions, they quit doing that because of too much red tape getting approvals, reimbursements, etc.

I well remember the afternoon when Steve and I were working on a project and Insoo stuck her head in the door to say a homeless guy was there and wanted to see her — what should she do? Well, it turns out this man had heard Insoo give a talk at a homeless shelter several weeks earlier and he decided he was ready to do something and so he came to the clinic. And, yes, he had already started cutting down on alcohol and started some new behaviour with his family!

**What other activities went on around the ‘sit behind the mirror’ experience which enhanced the team’s thinking? Walks together? Evening parties?**

There were often trainees, occasional members of the team, and other professionals behind the mirror in addition to the core BFTC staff when they didn’t have anything else they needed to do. Sometimes it was just a few people, and sometimes more than a dozen. Insoo and others would often heat up their supper in the microwave while behind the mirror, and there would always be free-floating conversations about almost anything, but all of this was interspersed with occasional discussions about what was going on with the case in front of the mirror, although that conversation didn’t really begin in earnest until after the break when the therapist came behind the mirror.

Steve would regularly take afternoon walks around the neighbourhood, and he would often ask me to join him if I was there. Insoo never took such walks — she was “too busy” for such things. I don’t recall anyone else on the team taking such walks.

Yes, parties in their home were a regular and important part of doing business for Insoo and Steve. They would hold these parties for trainees, for people who came in for week-long trainings, and for the frequent guests and collaborators that would come to the clinic from time to time. Steve and Insoo felt this was an important way to build relationships — to build community as we would say it now. Personal relationships with colleagues were also considered very, very important to spreading the word about the model.

**Who else shared that space with you during your time in contact with BFTC?**

The four full-time members of the team during the early 80’s were Steve, Insoo, Eve Lipchik, and Marilyn LaCourt. Elam Nunnally from the university was an important part-time member of the team. Alex Molnar, also from the university, was one of the instructors in the trainee program and I think helped people step outside the bounds of their usual ways of thinking. John Weakland was a frequent guest and supporter of the team’s work, as was Lyman Wynne.

**What do you remember as your own specific contributions to the process of developing SF?**

My contributions came mostly from the projects Steve and Michele and I did during the mid-80’s. The first one involved creating a coding system and then training my students to code interviews to see if we could figure out what was different about good interviews that made them stand out from the others. This led to the discovery that “change talk” was what differentiated the good



interviews from the not-so-good interviews, and subsequently we stopped doing the usual first session altogether since it dealt primarily with patterns of the problem (a strategic approach to assessment).

A second discovery related to the coding project came about one afternoon as we were training the students to code the interviews and Steve and I couldn't agree on whether what the client was saying should be coded as "change" or "no change." After some mulling over it dawned on us that the client was in fact describing change that had already occurred, but she didn't realize it as such, hence the addition of the code "unrecognised change" and the realization that these were important opportunities not be ignored but rather to engage the client in whether what she was describing was different, how did she make it happen, could she do it again, etc., etc.

Another project involved a computer science student at the university, Hannah Goodman, who wanted to develop an expert system that would embody the reasoning the team used behind the mirror to come up with compliments and a task. This was a knowledge mining approach to try to make explicit the still intuitive rules Steve and the team used to come up with a task. This led to the flow chart decision-tree that was published in *Family Process*, and became widely used in training at the clinic and in my teaching at the university. It made what seemed like an intuitive process clearly accessible to students learning the approach. I remember John Weakland's (tongue-in-cheek) comment when he came to town to do a presentation that we had best not let it out that 32 rules (of the expert system) was all that one needed to know to use the model!

### **If you were in that space again, what else would you wish to offer or change?**

That's a tough one. I can't really say I'd change anything. Obviously all of the ingredients necessary to create revolutionary change were present at BFTC during those years. It was an unusually energized, creative environment where team members fed off each other's ideas, and the discoveries we made as we carefully watched videotape after videotape to see if we could learn more about what worked and what didn't. I wouldn't change anything about that.

On the other hand, by the end of the early 90's as the core ideas of the Solution-Focused model had pretty much evolved Steve and Insoo began to spend more time training and consulting, and Eve Lipchik and Marilyn LaCourt had gone off to do their own things, the clinic eventually ceased operating as a clinic – it was now a training and consulting operation only. (This was

also during the time managed care was becoming the dominant reimbursement model in mental health services and referrals to free-standing clinics dropped off sharply.) Nevertheless, I believe that development of the model pretty much tapered off as the clinic's caseload went down and the trainee program began dwindling. I don't know that much could have been done to prevent this, since strong outside forces were at play. Also, I think it is exceedingly difficult — probably impossible — to maintain and institutionalize truly innovative and creative environments like that which existed at BFTC during the 1980's.

**To quote from David Hilbert (German mathematician, 1862-1943):**

**“The importance of a scientific work can be measured by the number of previous publications it makes it superfluous to read”. I think that SFBT fits that statement. What do you think?**

I would agree in the sense that we no longer need to learn about earlier approaches that are no longer useful. On the other hand, SFBT was clearly informed by the discoveries of earlier developments in psychotherapy, family therapy and epistemology, and I wouldn't consider those publications to be superfluous.

**To quote from the famous biologist JBS Haldane, talking in 1965: “Theories have four stages of acceptance:**

- 1. This is worthless nonsense.**
- 2. This is interesting but perverse.**
- 3. This is true but quite unimportant.**
- 4. I always said so.’**

**Which of these four stages do you think that SFBT is at now?**

Not sure I go along with those four stages, but I'd say SFBT is now at a stage where it is accepted as part of what students and practitioners need to know and be able to do, at least in social work. Managed care is also seeing Solution-Focused approaches as standard, even preferred, treatment, and SFBT is increasingly being considered an evidence-based treatment by important professional organizations.

I don't know that we'll ever get to the “I always said so” stage, at least not for a while. On the other hand, when my dad sat behind the mirror 30 years ago to see what I do his comment after the session was “so that's all you do!” To him, SFBT seemed commonsensical and not at all unusual, and I think he would have said we were already at stage 4.

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## About the authors

During his time on the Social Work faculty at the University of Wisconsin-Milwaukee, Dr Wally Gingerich was affiliated with the Brief Family Therapy Center (1982-1990), first as a trainee and then as a member of a small research team with Steve de Shazer and Michele Weiner-Davis. This group, assisted by graduate students from the University of Wisconsin-Milwaukee, carried out the “change talk” studies and the BRIEFER expert system project which were influential in the development of the Solution-Focused approach. Wally moved to Case Western Reserve University in Cleveland in 1990 but kept in frequent contact with Steve and Insoo, often inviting Steve to lecture to his doctoral seminar on social work practice.

Dr Alasdair Macdonald has been a consultant psychiatrist in the United Kingdom for 30 years with experience in work with offenders and a former Medical Director. He is a registered family therapist and supervisor who has written two textbooks and published original work about psychotherapy outcome and other interests. Past President of the European Brief Therapy Association, Alasdair is now a freelance SFBT trainer. Further information: [www.solutionsdoc.co.uk](http://www.solutionsdoc.co.uk)

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## **Solution-Focused Group Coaching: A Practical Guide**

Dr Carin Mussamann and Cornelia Decher  
2013. Self-published E-book.

### **E-book Review by Janine Waldman**

Director, The Solutions Focus

Carin Mussamann and Cornelia Decher have written an interactive and practical guide to group coaching. 'Solutions Focused Group Coaching' provides a blend of solutions-focused and systemic approaches to facilitating group coaching sessions. Focusing mainly on the application of group coaching to coach supervision and the professional training environment, it offers several practical examples of how this can be applied in managerial and organisational settings, with the authors demonstrating that the processes and methods are easily transferable between contexts.

A concise 80-page overview covers the four steps of their group coaching process — Introduction/ issue identification and clarification; working method selection; solutions development; tangible first steps and feedback. The book is packed full of tips, examples and guidance notes.

This is obviously a tried-and-tested approach to group coaching. The authors explain that they have been collecting feedback on the process for five years, which they have used to develop useful recommendations about timing, structure and the role of the coach.

The structure of the book is practical, first presenting us with the concept, described through different methods, then brought to life with case studies. These show a broad application of the approach, with 'clients' ranging from the self-employed coach who is looking for support as he writes and submits a tender, to the HR manager seeking guidance as she manages a new project.

The authors have fully utilized the e-book format which lends itself to the inclusion of photographs and videos. The book is easy to navigate, with

excellent indexing and glossary of terms, and the electronic format allows the reader to use highlighting and note-taking functions.

I particularly enjoyed the chapter on ‘future perfect interviewing’, which is one of the methods recommended for solutions development. It is comprehensively covered, with a video example of Carin interviewing Muriel, a special needs teacher, about supporting a student in his move to another school. There are also example transcripts of how to go about the interview — making the concept fully accessible for the reader, enabling them to grasp and apply the ideas. Scaling is also neatly explained with sample questions.

Other methods mentioned are Empty Chair work and Role Play. As I’m less familiar with these concepts, I would have welcomed the same level of detail here, as these are covered in a more theoretical and less practical way.

I was less taken with the focus on problems in Chapter 2 — where the authors assume a need to identify the current situation and define the issue, so that everybody in the group has an understanding of it. They note this as a systemic approach (as are other processes in the book) thus fitting with the premise that the book is aimed at those with an interest in both SF and systemic approaches. Given this, there is still plenty of choice for the SF purist to put the guide to good use.

I like the authors’ creative and extensive use of multi-media, with videos and pictures of sessions and materials, though I should declare an interest here, as this is one of the few books I’ve read with pictures of me (taken at a recent SOL summer retreat). I also discovered myself in a video clip explaining how Solutions Focus helps people and organisations recover from failure.

Overall, this book is definitely a practitioners’ guide, and those with an interest in group coaching would likely benefit from exploring the many tips, tools and case examples. The tone is friendly and professional and it certainly meets the authors’ stated aim, which is ‘to present the Solutions Focus Group Coaching Concept in a practice oriented, transparent and understandable way that will allow coaches, supervisors, consultants and managers to easily apply and implement it’.

Ebook. 80 pages plus video. Available on the Apple iBooks store £8.49/AU\$12.99. Also available on CD from [cornelia@decherlearning.com](mailto:cornelia@decherlearning.com).

## The reviewer

Janine Waldman has nearly two decades of experience in her specialisms of executive coaching, training and organisational development. As Director of coaching and change consultancy *The Solutions Focus*, she has introduced

Solutions-Focused approaches to individuals and organisations around the world. She is co-author of *Positively Speaking: The Art of Constructive Conversations with a Solutions Focus*.

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## Solution Building in Couple Therapy

Elliott Connie

(2012). Springer Publishing, New York.

### Reviewed by Don Coles

Cerebral Palsy Alliance, Sydney, Australia

In this elegant volume, Elliott Connie has combined the very personal story of his journey with couples, and couple therapy, with a concise description of the elements, ideas and skills of Solution-Focused process. The result is a refreshing voyage of discovery, dotted with anecdotes of his various encounters with people in the therapy room, his reflections on learnings along the way as he strives to keep true to the essence of the method (especially avoiding paths the model does not go down) and allowing the power of the process to do its work. So, this book is a testimony as much as a guidebook. His interest, passion and love of the work is clear through his writing.

There's a very nice story at the start about his "accidental" entre to this work — his first referral at his very first job as a therapist, where he was hoping to start his work with some sort of child and family situation, was for a couple. He did not feel at all confident to start off with this sort of client, and tried unsuccessfully to have someone else see them — but they wanted a male worker, and he was the only male in the agency, so he was booked in work with them. The session was not going well, there had been serious trouble brewing between this couple — feeling he was losing control of the session and not knowing what to say or do, Elliott asks, "So how did you two meet?". Somehow this produced a dramatic shift, significantly altering the tone of the session as they appeared to "become a different couple", opening up a positive and different context in which questions around their hopes for the session were able to be asked and explored. From that early experience of

being able to be helpful to a couple in serious difficulty, Elliott was effectively hooked on couple work, and this book is a result of that journey.

This book is a description, not an explanation. The various fundamental steps and processes of the Solution-Focused model are well described, organised into a few main chapters (i.e. establishing a destination; connecting with the couple; reviewing a couples' past successes; envisioning the preferred future; breaks, feedback, suggestions; follow up sessions) with a very useful concluding chapter titled "The questions" — in fact this brief 5 pages chapter would make a great generic Solution-Focused Therapy handout in itself. How these various ideas shape the therapist/client interaction are then demonstrated via transcripts of parts of sessions, some brief excerpts, and some more lengthy — the work with one particular couple is used as an extended example through the whole book, enabling us to see the process over time.

Elliot takes us inside the actual conversations, demonstrating the particular language structure of sessions, in a way that utilises and stays close to the language of the client. There is a useful discussion of the notion of using the words of the client's last answer to frame the next question, to keep the process as close as possible to the client's experience. I suppose this is a good communication technique generally, not something exclusive to Solution-Focused practice, but it certainly seems to be the case a Solution-Focused way of working assists, and is assisted by, this mode of communication. Similarly there is a very helpful description and discussion of the idea of "turn taking" in the 3 way therapist/couple conversation, and useful ways to think about this process.

I particularly appreciated the reminder in the book that a fundamental notion in the Solution-Focused model is that finding out first about the desired destination is crucial. Nothing (or maybe very little) can happen therapeutically until some notion of this for the clients, however small, vague, tentative, is understood by the therapist. Elliot has a wonderful illustration of this — he became lost walking in a foreign city, and hailed a taxi to get back. He didn't have the name of the hotel, and the cabbie, before setting off, asked some detailed questions about the appearance and location of the hotel. Only when the cabbie recognised Elliott's description, and was confident he knew the destination, did he then set off in the cab. So the journey was not commenced until there was some clarity of where they were going. Elliot makes the helpful point that this way of looking at the process of therapy may be more useful than the one of client "goals".

I was reminded of this recently in a process with a very challenging family I am working with in a home-visiting context, where a dad has been quite involved in various discussions about how he sees his family and what is

going on with his son — despite me asking a number of questions around what would tell him that things are getting better, it has taken until my 6th session for me to hear from this dad, in all the things he has said so far, something that is an articulated goal (destination) that he has for himself, that he would like to possibly like to work towards. Now, there may well have been ways to come to this sooner in the process of my work (although I actually doubt it), but thinking about the ideas in Elliott's book has helped me be patient with the process in working with this dad, and not try to do too much with him until I hear something from him that sounds like a destination he wants to get to — now that I've heard something like this, I feel I can now actually start to work with him therapeutically.

One of the great things about this book is the sense that Elliott trusts his clients and trusts the process — he is active, deliberate and rigorous in steering the therapy via the Solution-Focused roadmap, in a way that leaves the couple to fill in the important life details about what they want, what this looks like, what would be evidence of this, and how would they know this was happening etc. So it's a dance where the therapist plays his part and the clients play their part — Elliott captures well the wisdom of targeted questioning and curiosity and the patience of waiting for the details to emerge, and having faith and trust in the process.

Although the style and purpose of the book is to be brief (at 115 pages), there were a couple of things I would have liked to have heard more about. In some of the case examples, Elliott alludes to some of the very difficult and stressful problems that couples come with. The spirit of Solution-Focused practice is for people to leave these behind, not dig them up, so it fits that a book like this would not focus too much on this. However, I would have liked a bit more discussion, maybe even just a small chapter, on some of the different common types of difficulties that couples come with, and any thoughts Elliott has on particular considerations with these (accepting that the Solution-Focused process is not determined by the shape or nature of the problem). Some of these may be domestic violence, drug and alcohol issues, family of origin issues, mental health problems, in-laws related problems, affairs (this is mentioned a few times in the case examples) — does he have some different senses of what needs to be kept in mind in using the Solution-Focused method in these situations?

Also I feel the book would be enhanced by a little wider referencing and acknowledgement of some of the ideas that have been developed and used in other models or traditions of therapy. For example, the very useful idea of the therapist being a "curious observer ... helping the couple uncover even the smallest details" (p. 57) reminded me of the distinguished history of the



power of curiosity as a therapeutic stance in Post-Milan systemic work. The relational notion of using “third person questions to bring the absent partner into the conversation” (p. 99) has also been used widely in the systemic model (see, for instance, Brown, 1997). Similarly, the discussion about the power of the “How did you two meet?” question is very helpful, but there is no reference or acknowledgment that this is not actually a new idea in couples work. For example Solomon (2010, p. 360) describes the question, “Tell me more about you as a couple. How did you meet?”, and explains that this “invites a couple to revive moments of positive feelings in their relationship”. I acknowledge that in a slim volume such as this there is a practical limit on how much can be referenced, and for what purpose, but I feel this would help to place it in some sort of wider historical context, apart from the brief therapy and Solution-Focused historical influences that are mentioned. This also may be helpful for readers who are already familiar with some of these other modalities, to assist them not only to discern in this book the distinctiveness of Solution-Focused work, but also to see that some of the connections to other traditions are recognised and valued.

To me this book is a great example of the importance, for us as therapists, of finding enjoyment and interest in what we do, whatever the particular area of clinical practice. A few times while reading his book I had the urge, inspired by Elliott’s love of what he is doing, to just try and find more opportunities to work with couples, which I do get in my current role from time to time. Maybe this is fine to do (and no doubt this book will be very helpful when I do that), but maybe that is missing the wider point — that our challenge is to find this passion and interest in whatever therapeutic opportunity sits in front of us, with our very next client, of whatever sort they are or whatever service we may be offering. Certainly this book is a reminder of how a commitment to a Solution-Focused process, if one understand this and practices it well, can help build and maintain that passion and interest.

Thanks Elliott, it’s a great contribution to our body of knowledge of Solution-Focused practice, with couples but also more generally.

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Paperback. 136 pages. US price: \$55.00 Kindle e-book edition \$41.57. Australian distributor: Footprint Books ([www.footprint.com.au](http://www.footprint.com.au)) AU\$63.00

### **The reviewer**

Don Coles is a Social Worker and Family Therapist with the Cerebral Palsy Alliance in Sydney, providing family support, counselling and intervention to families with children and teenagers with disabilities, and supporting and mentoring other staff with this. The pressures of having a child with a disability often exacerbates any strains within the couple's relationship, so Don has done more than his share of couple therapy. Don enjoys surfing, cycling, playing guitar, coffee with friends, reading (Cormac McCarthy at the moment), live music, belonging to a church community, watching rugby and spending time with his family.

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## **Working with Children and Teenagers Using Solution Focused Approaches: Enabling Children to Overcome Challenges and Achieve their Potential**

Judith Milner and Jackie Bateman  
(2011). Jessica Kingsley Publishers, London.

### **Book review by Bronwen Elliott**

Independent Social Work consultant

When I read a book for therapists the first test is whether the book helps me think more clearly and hopefully about my work. Milner and Bateman's succinct presentation of the key elements of Solution-Focused work and their numerous examples effectively reminded me of the importance of rigour and persistence in taking a solution focus, and of the impact of Solution-Focused conversations where the usual talk is about what is going wrong.

Milner and Bateman explore goal setting, with an emphasis on the 'best hope' exception finding, exploring children's strengths, and using scaling.

Their approach to a solution focus also embraces narrative therapy, drawing elements such as externalising and therapeutic letter writing, with particular reference to Freeman, Epston and Lobovits' (1997) book, *Playful Approaches to Serious Problems*. Milner and Bateman are confident to describe Solution-Focused approaches to situations that often provoke pessimism, such as children who have sexually abused other children or children with eating disorders. They include practical reflection tasks that would be useful for supervisors and team discussion, and many example of Solution-Focused questions for work with children across a range of ages. A particular strength of the book is the practical tips they provide about working directly with children, such as different approaches to scaling for different age groups, swapping roles between children and parents and ways to identify goals with children who don't like talking, or find it hard to express ideas. Their depth of experience was evident in situations such as the teenager whose post miracle day involved an endless free supply of drugs and drink and the involvement of the family dog in work with a family where everyone had different ideas about the problem.

Milner and Bateman are based in the UK, and seek to locate their work within UK government strategies. This discussion will be of little relevance to practitioners outside the UK, and some of the terminology used may not be familiar, but this does not detract too much from the experience of the reader. Milner and Bateman borrow case examples both from Milner's own previous publications and from Freeman *et al* (1997). I can't recall examples of similar recycling elsewhere, and given the quality of the original material in this book, this seemed unnecessary.

Milner and Bateman are writing in a context where even government policy documents refer to the importance of acknowledging children's strengths. While there is much greater familiarity within the workforce of the 'talk' of solutions, this may not mean children actually experience the 'walk' in their work with practitioners. Milner and Bateman's patient explanations about why children and young people find advice giving unhelpful say quite a lot about the gap between rhetoric and reality in this respect. They emphasise that talking about solutions and giving compliments is very different to exploring a child's best hopes and finding out how they have managed to take steps towards those hopes in spite of challenges in the way.

The other significant contextual issue that Milner and Bateman seek to address is the intersection of their hopeful work with children and young people and concerns about safety. They include short sections on exception finding and scaling in child protection (or to use the UK term 'safeguarding') situations, and provide case illustrations including court involvement. They also

refer briefly to Turnell and Edwards (1999) 'Signs of Safety' approach, and note somewhat bluntly that 'where there are no exceptions, there is increased danger and children will need to be removed from their families.' Few of the case scenarios have a definitive outcome, so that Milner and Bateman avoid implying that if practitioners just focus on solutions all will be well. On the other hand because detailed outcomes are not explored the reality of solution focused work in the face of uncertainty about an individual or family's capacity to demonstrate safety is not addressed. To my mind however this is the reality practitioners will need to face in order to persist with Solution-Focused approaches while maintaining clarity about safety and progress. While this book has much to offer practitioners, I would suggest it be used alongside careful discussion of safety, both in relation to the scenarios within the book, and families where strategies gleaned from the book might be applied.

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Paperback. 176 pages. UK price: £19.99. Australian distributor: Footprint Books ([www.footprint.com.au](http://www.footprint.com.au)) AU\$39.95. Kindle ebook edition £10.30/AU\$16.77

## The reviewer

Bronwen Elliott is an independent social worker based in Sydney and consults to a range of government and non-government agencies working with children and families. She is especially interested in the use of solution focused approaches in child protection work and supervision.

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