1 Solution-focused therapy: twenty years on

The emergence of solution-focused therapy in the 1980s: context and antecedents

Solution-focused therapy (SFT) was developed in an American clinical family therapy setting in the 1980s, a particular context and time when family therapists had some specific challenges to contend with. The initial target audience for its dissemination was the community of American family therapists, peers of de Shazer, Berg, and their team in Milwaukee. Three factors that both provided a receptive context for the development of SFT and also acted as antecedents to its development are: (1) the field of family therapy itself; (2) the increasingly convincing case for brief approaches; and (3) the existence of brief strategic therapy.

The field of family therapy itself

A review of the evolution of family therapy up to the 1980s indicates a dynamic and ever-changing expansion of ideas focused on a family orientation. Cybernetics (the study of control and regulatory systems), family systems theories, and Bateson’s work on communication were influential in shaping the new therapy. Gregory Bateson, John Weakland, Jay Haley, Virginia Satir, and other members of the Mental Research Institute in California were significant early innovators in family therapy, as were Salvador Minuchin (associated with structural family therapy) and Monica McGoldrick and Betty Carter (associated with the changing family life cycle and developmental stage therapy) on the east coast of the USA. European theorists of note – including prominent teams from the UK, Ireland, and Italy – also emerged during this time.

An ever-increasing range of approaches in the 1970s widened the popularity and influence of family therapy primarily through individual, charismatic, and gifted therapists who became international celebrities. These were the
valued communication channels of the time, long before information technology had such an impact on the dissemination of ideas and information. As the field expanded, attempts to classify different approaches met with varying degrees of success, with one author by the mid-1980s admitting defeat: ‘It is said there are as many ways of practising family therapy as there are workers in the field’ (Burnham, 1986: 62). By the late 1980s, not only was there a plethora of family therapy models but also concern that claims for its effectiveness were overstated.

By the early 1990s, family therapy was assailed by a wider range of criticisms. Feminist critiques, such as those of Hare-Mustin (1978, 1987) and Pilalis and Anderton (1986), identified a blindness to gender difference in systems theory and the low status and lack of attention paid to traditional female roles of caretaking and nurturing as issues of concern. Consumer studies, such as that of Howe (1989), were indicating that: clients did not feel understood by family therapists on their own terms; sessions were dominated by therapists who set the agenda; and clients felt powerless and disliked videotaping and live supervision. Howe came to the conclusion that systemic family therapy was unable to understand the significance of individual personal experience, banishing the subjectivity of the user and preventing a genuine dialogue taking place between the user and their therapists. In their searching review and critique of family therapy, Reimers and Treacher (1995) found that: first, (at that time) claims for most models were not supported by empirical findings (with the exception of behavioural and psycho-educational models); second, many of the major theorists of the time did not demonstrate any commitment either to validating their results or exploring the service-user’s subjective experience; and third, there were problems with theory development and dissemination. The family therapy movement itself was charged with being:

disproportionately shaped by the influence of charismatic leaders performing (literally) as showmen at important conferences and workshops . . . apparently highly effective interventions are demonstrated by skilful practitioners who are excellent showmen. Failures are typically not shared and there is usually little attention paid to research findings. Many of the presenters of such workshops actually earn their living from their presentations so there is often an in-built marketing factor which militates against presenters being objective about their own successes and failures.

(Reimers and Treacher, 1995: 24–25)

The conclusion Reimers and Treacher reached was that if family therapy was to fulfil its potential as an ethical and effective practice, more attention had to be paid to the user’s perspective and less to a fascination with
versions of systems theory, which rendered the user (and individual subjective experience) invisible.

The increasingly convincing case for brief approaches

An important debate in family therapy (and indeed individual therapy) at the time also focused on the relative benefits and disadvantages of short-term versus long-term approaches. This is a subject of enduring interest not only to practitioners but also to policy-makers and public service managers responsible for the ethical and efficient use of resources. In the early twentieth century, Freud and collaborators such as Sandor Ferenczi initially practised psychotherapy in brief and concise forms (Budman, 2002). In the mid-1950s, family therapists were using brief treatment approaches, although these were not formalized into models for practice until the late 1970s (Erickson, 1954; Haley, 1973). Long-term work was seen to be expensive, demanding for practitioners and clients, and risked creating problems of dependency. There were also fears that long-term therapy could become directionless. Motivation was thought to be highest at the initial crisis point of seeking help or in the first few sessions. Research results indicated that clients not only preferred brief interventions but also generally tended to stay in therapy for between six and ten sessions (Reid and Shyne, 1969; Garfield and Bergin, 1978; Koss, 1979). It was also shown that those receiving brief interventions (six to eight sessions) achieved significantly more positive change than those receiving an open-ended service (Reid and Epstein, 1972), and that changes made in short-term treatments were at least as durable as those in longer-term interventions (Reid and Shyne, 1969; Fisher, 1984). As the issue of cost-effectiveness became more compelling, the case for favouring brief therapies and interventions grew (Barker, 1995). The increasing focus on short-term interventions has not been without its critics however. Some have linked the growth of short-term focused interventions to an increasing emphasis on ‘surface’ over ‘depth’ (Howe, 1996) in helping methods; others (Stevenson, 1998) have raised concerns about the appropriateness of short-term targeted interventions with particular problems such as chronic child neglect. Some of Stevenson’s concerns mirror those of Howe regarding the lack of attention paid to meaning and causal theories in the rush to be brief:

The need to find meaning in the behaviour of neglectful parents is a prerequisite for effective work with them . . . Why cannot a parent control or protect their children? Why do some parents live in utter squalor and discomfort?

(Stevenson, 1998: 113)

Advocates for SFT, as a therapy that initially not only carried but promoted the label of a brief form of intervention at a time in the 1980s when such
approaches were in particular vogue, probably contributed to the notion that all problems could be solved in the short term and so played into the hands of North American health insurers and service providers who at the time introduced restrictions on lengths of treatment. The introduction of ‘Managed Care’ by health insurers in the USA at the time was seen to be particularly detrimental. Although the initial emphasis on brevity had these unintended consequences, it is important also to recognize that for de Shazer the central point was that professionals should not overstay their welcome in clients’ lives, and should seek to help clients make necessary changes as speedily and as efficiently as possible. Nor was the emphasis on brief interventions embraced by all SFT advocates. Lipchik (1994) specifically criticized this element of the early practice model. Although the central notion that formal helping interventions should be, wherever possible, brief, effective, and efficient, these critiques remind us of the risks of a rush to be brief, the heterogeneity of ‘problems’, and the complexity of processes of change.

The existence of brief strategic therapy

Brief strategic approaches are the true precursors to SFT. Strategic therapy has been defined as a combination of ‘a communication systems approach, the use of paradox and the strategic wizardry of Milton Erickson’ (Guerin, 1976: 20). While this is a somewhat dated definition, it is the most useful for the purpose of comparison here. Erickson’s work as a psychiatrist and therapist in the 1940s and 1950s was ‘uncommon’ for the time, especially when viewed against the prevailing psychodynamic orthodoxy, in particular his use of paradoxical injunctions and the use of metaphor in communication (Haley, 1973). The Mental Research Institute (MRI) founded by Don Jackson in Palo Alto, California in 1959, brought together some of the original members of Gregory Bateson’s communication project team, such as Haley and Weakland, and incorporated ideas from Erickson’s uncommon techniques to establish the MRI Brief Therapy Project. Their approach was outlined in two major publications in 1974: a book entitled Change: Principles of Problem Formation and Problem Resolution (Watzlawick et al., 1974) and a paper in the journal Family Process, ‘Brief therapy: focused problem resolution’ (Weakland et al., 1974). Defining brief therapy as (i) focusing on observable behavioural interaction in the present and (ii) involving deliberate interventions to alter the ongoing system, the MRI group claimed a new conceptualization of the nature of problems as well as their resolution. Brief therapy in this mould was characterized by the absence of any ‘elaborate theory of personality or dysfunction’ and relied instead on simple diagnostic formulations that would allow therapists to intervene as briefly and effectively as possible (Cade and O’Hanlon, 1993: 5). It was based on the premise that the types of problems people need help with persist only if they are maintained by ongoing behaviour by themselves and
others (in other words, ‘stuck’ patterns of behaviour or thinking), and that
the problematic behaviour or thinking is not in itself a symptom of a deeper
systemic dysfunction thus obviating the need to engage in self-exploration or
focus intensively on the past. The role of the therapist becomes that of an
active agent of change (and more of this later) whose aim is to intervene ‘to
alter poorly functioning patterns of interaction as powerfully, effectively and
describe brief therapy as concentrating on promoting change rather than pro-
moting growth, understanding or insight; where the role adopted by the helper
is one of agent of change; which uses the term *interactional* rather than sys-
temic; and focuses on ‘observable phenomena, is pragmatic and related to the
belief that problems are produced and maintained 1. by the constructs through
which difficulties are viewed, and 2. by repetitive behavioral sequences (both
personal and interpersonal) surrounding them . . . (which can) . . . include the
constructs and inputs of therapists’ (Cade and O’Hanlon, 1993: 5).

In summary, the context of American family therapy at the time that SFT
emerged from Milwaukee in the 1980s was one where established methods
of family therapy were considered by some to be over-technical and anti-
humanistic, overly popularized by high-profile charismatic leaders in public
performances, under-developed in terms of evidence of effectiveness, and lacking in service-users’ perspectives. Despite valid concerns about the growing
dominance of brief methods of interventions (and what that indicated about
broader changes in social conditions where health insurers and service prov-
iders were limiting budgets for psychological therapies), there has been an
enduring interest in them to the point now when brief therapies are the
type most commonly offered (Macdonald, 2007). Brief therapy as it emerged
from the MRI group offered a template for a short-term intervention with a
pragmatic focus on problem resolution. Strategic therapies had fallen into dis-
repute primarily because of concerns about the ethics of some techniques,
such as paradoxical injunctions (Carr, 1995). This, then, was the context
within which SFT found favour.

Given the range of criticisms that family therapy was attracting at the
time, the appeal of SFT is understandable: operating from principles that
emphasize the client as a person of resources, it questions the assumption that
the therapist/helper knows best, redefining the role of the therapist/helper as
facilitator and collaborator rather than all-powerful expert.

**The emergence of solution-focused therapy**

Solution-focused therapy is attributed to Steve de Shazer, Insoo Kim Berg,
and their colleagues at the Brief Family Therapy Center (BFTC) in Milwaukee,
Wisconsin (de Shazer, 1985, 1988, 1991; de Shazer et al., 1986). The original team at BFTC also included Eve Lipchik, Elam Nunnally, Wallace Gingerich, and Michelle Weiner-Davis. That the development of the model was a collaborative exercise centre primarily on the partnership of de Shazer and Berg (but with other team members contributing a significant role) is evident from subsequent publications and presentations. While this chapter will continue to refer to the model as ‘de Shazer’s’ (because he authored most of the seminal publications in the 1980s and 1990s from the BFTC), it is in my view more accurate to view de Shazer and Berg as joint developers of SFT but with others deserving credit for their role as members of the original clinic team. The later publications by de Shazer and Berg prior to their deaths in September 2005 and January 2007, respectively, reflect more accurately the central role Berg played in the refinement of the model across a range of practice settings (Berg and Kelly, 2000; Berg and Dolan, 2001; Berg and de Jong, 2002; Berg and Steiner, 2003). As subsequent publications by Lipchik (2002), Weiner-Davis (O’Hanlon and Weiner-Davis, 2003), and other members of the original team make clear, they too have a legitimate claim to the increasingly broad church of solution-focused approaches.

After years of experimentation on different pathways through the therapeutic process, always focused on a pragmatic search for ‘what works’, and informed by close observation and review of bona fide therapy sessions, de Shazer and Berg made their conceptual advance in the early to mid-1980s. Both have always acknowledged the influence of other theorists and model-builders, in particular Gregory Bateson, Milton Erickson, and John Weakland (de Shazer et al., 2007). De Shazer also saw his development of the solution-focused model as a progression of the MRI approach:

> We have chosen a title similar to Weakland, Fisch, Watzlawick and Bodin’s classic paper, ‘Brief Therapy: Focused Problem Resolution’ to emphasize our view that there is a conceptual relationship and a developmental connection between the points of view expressed in the two papers.

(de Shazer et al., 1986: 207)

In the early publications, the roots of the SFT approach in strategic therapy were obvious not only in de Shazer’s conceptualization of problems, the change process, and an intervention model (de Shazer, 1985, 1988; de Shazer et al., 1986), but also in his adoption of many features of the MRI approach, including:

- **reframing** (defined as changing ‘the conceptual and/or emotional setting or viewpoint in relation to which a situation is experienced and to place it in another frame which fits the “facts” of the same situation**
equally or even better, and thereby changes its whole meaning’; Watzlawick et al., 1974: 95);

- the use of tasks; and
- the depiction of different levels of commitment to change.

The connections between Erickson’s formulation of strategic therapy, the bridge of the MRI brief therapy model, and de Shazer’s starting point for SFT are clearly shown when mapped as in Box 1.1.

While incorporating these components, de Shazer also departed from the MRI model in several significant ways:

- the use of compliments and the active elicitation of exceptions and strengths;
- the emphasis on the development of a cooperative relationship; and
- the shift from task to process.

Solution-focused therapy, as initially developed, consisted of a formulaic,

<table>
<thead>
<tr>
<th><strong>Box 1.1</strong> Conceptual linkages between Erickson and de Shazer</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Erickson’s 12 ‘uncommon techniques’</strong></td>
</tr>
<tr>
<td>Encouraging resistance</td>
</tr>
<tr>
<td>Communicating in metaphor</td>
</tr>
<tr>
<td>Encouraging a relapse</td>
</tr>
<tr>
<td>Emphasizing the positive</td>
</tr>
<tr>
<td>Seeding ideas</td>
</tr>
<tr>
<td>Amplifying a deviation</td>
</tr>
<tr>
<td>Avoiding self-exploration</td>
</tr>
<tr>
<td>Amnesia and the control of information</td>
</tr>
<tr>
<td>Awakening and disengagement</td>
</tr>
<tr>
<td>Providing a worse alternative</td>
</tr>
<tr>
<td>Encouraging a response by frustrating it</td>
</tr>
<tr>
<td>The use of space and position</td>
</tr>
</tbody>
</table>

| **De Shazer’s 7 corresponding interventions**                |
| Resistance – the family’s unique way of cooperating         |
| Constructing metaphors using client’s phraseology           |
| Prediction of setbacks/emphasis change as non-linear        |
| Clients viewed as doing their best; use of compliments      |
| Possible solutions suggested as ‘clues’                     |
| Exceptions – elicit, amplify, reinforce                     |
| Concrete goals and future focus/avoid problem-focus         |

Erickson’s uncommon strategies expanded from Haley (1973). Many also present in MRI work.
staged practice model for a clinic-based session (de Shazer et al., 1986) in a deliberate and conscious replication of the 1974 MRI model. De Shazer’s 1985 and 1988 books developed the theory behind the main concepts in the model, while his two later books in 1991 and 1994 developed the philosophical foundation of his theories of therapy and in particular his reconceptualization of therapy as a language-game, as he was increasingly influenced by Wittgenstein’s work on the philosophy of language. The final posthumous publication (de Shazer et al., 2007) provides a useful insight into their (de Shazer and Berg) thinking some twenty years on. While they restate many of the core concepts of the approach, they also highlight new aspects – for example, the role of the therapist/helper is now acknowledged as being located within a hierarchical relationship, not one of equality with clients.

There follows a quick summary of SFT as originally developed before we consider its subsequent linkage with social constructionism and postmodernism.

**Core principles of solution-focused therapy**

De Shazer et al. (1986: 208) describe the key to SFT as: ‘Utilising what clients bring with them to help them meet their needs in such a way that they can make satisfactory lives for themselves’. The main principles underlying the approach are:

1. Problems develop and are maintained in the context of human interactions. Individuals possess ‘unique attributes, resources, limits, beliefs, values, experiences and sometimes difficulties, and they continually learn and develop different ways of interacting with each other’ (p. 208). Solutions lie in ‘changing interactions in the context of the unique constraints of the situation’ (p. 208).

2. The aim is to get clients doing something different, ‘by changing their interactive behaviour and/or their interpretations of behaviour or situations so that a solution (a resolution of their complaint) can be achieved’ (p. 208).

3. Clients are viewed as experts on their own lives. De Shazer subscribes to Erickson’s belief that individuals have a reservoir of wisdom learned and forgotten but still available. The task of the practitioner is to facilitate the client in making contact with forgotten or unnoticed wisdom.

4. ‘Resistance’ is viewed not as a label to be affixed to particular clients (usually deemed to be uncooperative), but as ‘the client’s way of letting us know how to help them’ (p. 209). The key to cooperation is ‘to connect the present to the future (ignoring the past, except for
past successes) . . . point out to the client what we think they are already doing that is useful and/or good for them, and then – once they know we are on their side – we can make suggestions for something new that they might do which is, or at least might be, good for them’ (p. 209).

5 The meanings attributed to particular behaviours are seen to be of significance, especially in relation to the detrimental effects of labelling. The meaning that any behaviour is given depends on perception and perspective. Reframing is therefore proposed as a way in which ‘new and beneficial meaning(s) can be constructed for at least some aspect of the client’s complaint’ (p. 209).

6 Goals should be small and achievable, since only a small change ‘can lead to profound and far reaching differences in the behavior of all persons involved’ (p. 209). The bigger the goal identified or the bigger the desired change, the more difficult it is to either establish a cooperative relationship or to achieve success. De Shazer (1991) subsequently articulated more fully the qualities of well-formed goals (reproduced later in this chapter). One small change in one part of an interactional system leads to changes in the system as a whole. Individual change can trigger interactional change.

7 Perhaps most controversially, de Shazer initially insisted that solution-construction did not require a detailed knowledge of the problem pattern: ‘How will we know when the problem is solved? . . . Details of the client’s complaints and an explanation of how the trouble is maintained can be useful for the therapist and client for building rapport and for constructing interventions. But for an intervention message to successfully fit, it is not necessary to have detailed descriptions of the complaint. It is not even necessary to construct a rigorous explanation of how the trouble is maintained’ (p. 209). This stance was unsustainable in practice and the SFT model clearly incorporates a stage of quite detailed problem exploration prior to action.

The 1986 clinical model of de Shazer et al.

It is worth noting the different stages in the helping process as initially formulated:

1 Pre-session change. On the basis that asking for help in itself is a new behaviour (and that this change in itself can lead spontaneously to other changes), and one that the self-referring client can take full credit for, the client is given a task when making an appointment:
‘Between now and the time when we meet, can you look out and note any changes or differences (in the problem)?’

2 Problem-free talk (building rapport and locating strengths). In this phase of the interview, the worker is encouraged to connect with the person, find out a bit more about them beyond the parameters of the problems, and note what the client does well, what adversity they have overcome, and what strengths they display. The practitioner starts to listen with a constructive ear (Lipchik, 1991) for the strengths that the client brings and ways they have already developed to deal with adversity.

3 Statement of the problem pattern. Although de Shazer maintained that for an intervention message to fit successfully it is not necessary to have a detailed picture of the problem, in practice some exploration of the problem pattern almost always takes place. The point de Shazer was emphasizing is that detailed explanations of problem patterns may not necessarily lead to solutions, as problem patterns and solution patterns may be dissimilar. An experimental trial by Macdonald (2007) and his team in Scotland in omitting to ask for any information about ‘the problem’ resulted in negative feedback from clients and this approach was abandoned.

4 Exploration of solution patterns. This takes place by eliciting and amplifying exceptions to the complaint and successful attempts to diminish its effects, and by eliciting and amplifying successful behaviour and thoughts in other areas of life. The focus is on interactional processes, which either maintain a problem pattern or interrupt it. The search for exceptions (through the use of such questions as, ‘tell me about the times when it doesn’t happen/when it’s less bad/when you say “no”’) is seen to be an intervention in itself, as it implicitly lets the client know that there are times when they are being effective, and therefore reframes them as competent rather than powerless in the face of the problem. It can therefore provide some hope for clients that problems can be solved or alleviated or that they can be competent and resilient in the face of problems. The importance of language in the careful framing of questions is implicit in this approach. Exceptions are amplified by the worker as they will help ‘to create the expectation that a future is possible which does not include the problem’ (de Shazer et al., 1986: 210).

5 Goal-setting is emphasized as crucial, so that both worker and client will know when it is time to terminate contact. This phase is also important because the essence of SFT is to convey to the client that change is not only possible but inevitable. Goal-setting also provides a clear focus for therapy, and facilitates evaluation of progress and outcome. Two techniques most associated with SFT – The Miracle
Question and Scaling Questions – are actively used to determine progress towards well-articulated goals. De Shazer later elaborated on the characteristics of well-formed goals as outlined in Box 1.2.

6 The small steps of change. Once specific, observable goals are co-constructed along the lines suggested above, small steps of change can be mapped out. De Shazer sees this as an intervention in itself, in that the more time spent in a session on ‘change talk’, with the focus being on the absence of the complaint and what will replace it, the more it creates the expectation that change is not only possible but inevitable.

7 The ‘break’ and the message/homework. A planned interruption in the session when the practitioner devises the message to be delivered to the client at the end of the session. What is emphasized is the importance of the ‘fit’ (i.e. the relevance) of the message. The task for the practitioner is to devise a message that shows a client that their situation is understood and that acknowledges them (compliments) while also flagging up possible solutions that the client may find acceptable (clues). Compliments are designed to establish a ‘yes set’ (Erickson and Rossi, 1979) of agreement from the client so that he or she would be more receptive to the clues or directions put forward. However, positive feedback has since been built into the fabric of the session by many practitioners as an important challenge to the view of self as powerless or at fault. De Shazer initially developed a series of formulaic tasks to be given in homework but these are not too commonly used in practice now.

This, then, is the essence of the SFT model as it was initially developed in 1986 and, as already noted, disseminated in an influential journal (Family Process) to peers in family therapy settings. The emphasis was on a minimalist prescription

<table>
<thead>
<tr>
<th>Box 1.2</th>
<th>Characteristics of well-formed goals (de Shazer, 1991: 112)</th>
</tr>
</thead>
<tbody>
<tr>
<td>‘Workable goals tend to have the following general characteristics:</td>
<td></td>
</tr>
<tr>
<td>1 Small rather than large;</td>
<td></td>
</tr>
<tr>
<td>2 salient to clients;</td>
<td></td>
</tr>
<tr>
<td>3 described in specific, concrete, behavioural terms;</td>
<td></td>
</tr>
<tr>
<td>4 achievable within the practical contexts of clients’ lives;</td>
<td></td>
</tr>
<tr>
<td>5 perceived by the clients as involving their “hard work”;</td>
<td></td>
</tr>
<tr>
<td>6 described as the start of something and not as the end of something;</td>
<td></td>
</tr>
<tr>
<td>7 described as involving new behaviours rather than the absence or cessation of existing behaviours.’</td>
<td></td>
</tr>
</tbody>
</table>
for therapy with the development of a single session model. Only as SFT became known and popularized outside of clinical therapy settings did its adaptability and versatility become more evident and the focus move beyond the initial session. Initially adopted by family therapists, the model began to attract a more general interest from those in the helping professions from the end of the 1980s onwards. It has since been modified for work in various settings, with diverse client groups and types of problems, across the globe – from Asia to continental Europe, North America to the Antipodes. The last published work outlining the core approach from de Shazer and Berg (de Shazer et al., 2007) reiterates the major interventions of the approach and illustrates how they have retained a consistency since 1986. They are outlined in Box 1.3 later in this chapter.

Is solution-focused therapy a strategic form of therapy?

Both in 1986 and in subsequent publications, de Shazer explicitly conceptualized his SFT model as a derivative of but different from the Mental Research Institute (MRI) model of brief strategic therapy. That SFT is both strategic and complementary to the MRI model was a view expressed by members of the MRI team: ‘At a specific level, I do not think the use of the term “strategy” necessarily implies a contest between therapist and client; indeed I would propose that de Shazer carries on his therapeutic conversations strategically’ (Weakland, 1991: viii). Some analysts agree that the SFT and MRI models are more similar than different (Cade and O’Hanlon, 1993; Shoham et al., 1995) and that the SFT model is a strategic approach (Weakland, 1991; Shoham et al., 1995) or at least consistent with strategic approaches (Gale and Long, 1996): ‘We focus primarily on attempted solutions that do not work and maintain the problem; de Shazer and his followers, in our view, have the inverse emphasis. The two are complementary’ (Weakland and Fisch, 1992: 317).

While solution-focused techniques may be used strategically, the innovations de Shazer introduced are in my view sufficient to locate it outside the realm of brief strategic approaches. These include:

1. The emphasis given to the concept of future-focused ‘solutions’ as opposed to resolution of the problem.
2. The reformulation of the therapist–client relationship as a co-constructivist and collaborative relationship, albeit with the more recent caveat that solution-focused helpers ‘accept that there is a hierarchy in the therapeutic arrangement, but this hierarchy tends to be more egalitarian and democratic than authoritarian’ (de Shazer et al., 2007: 3–4).
3. The focus on process rather than interventions and the emphasis
placed on alternative possibilities and meanings that the therapist offers the client through the construction of solution-focused conversations. By 1985 de Shazer saw therapeutic change as ‘an interactive process involving both client and therapist’ (de Shazer, 1985: 65). Despite this, the approach does make use of particular techniques, mainly through a particular form of questioning.

4 The view of clients as essentially cooperative and as experts on their own lives. From his earliest writings, de Shazer was interested in how the most effective relationship could be developed between therapist and client and he began to note the differences in levels of cooperation that were elicited by various strategies, such as the use of compliments. In his 1982 model, the contact with families began with what was termed the ‘prelude’, where the therapist tries ‘to build a non-threatening relationship with the whole family and to learn something about how the whole family sees the world’ (de Shazer, 1982: 27).

5 The abandonment of the need for a team approach. By 1985 de Shazer viewed the team as dispensable: ‘A team is not necessary for working this way’ (de Shazer, 1985: 19).

6 The rejection of task-setting as a central feature of therapy: ‘Accepting non-performance as a message about the client’s way of doing things allowed us to develop a cooperating relationship with clients which might not include task assignments. This was a shock to us because we had assumed that tasks were almost always necessary to achieve behavioural change’ (de Shazer, 1985: 21).

7 The emphasis on meaning and on the client’s subjective experience, beliefs, and values.

8 The importance of language, particularly the craft of constructing useful questions and utilizing the client’s own terminology in describing both problem and preferred futures.

Specific techniques, such as the Miracle Question, the identification of exceptions, and the use of scaling are arguably strategic in origin. In its initial conceptualization, the SFT model was highly prescriptive in its six-stage formula. Despite this, de Shazer can be said to have fundamentally altered the balance of power in the therapeutic relationship away from a strategic stance by suggesting that therapists should start from a viewpoint of seeing the client rather than the therapist as holding the key to the solution. The role of the therapist in the SFT model became one of a facilitator who helps the client ‘discover’ forgotten wisdom and who does so through a firm focus on the future and the concept of goal-setting through the detailed description of a preferred reality, an element of the approach not previously centre-stage in therapeutic endeavours and still very distinctive in solution-focused helping.
One answer to the question of whether SFT is strategic or not has to be: ‘it depends’. And it depends on how SFT is interpreted and practised by individual practitioners. In the hands of one it could be highly strategic, whereas in the hands of another not at all strategic. It is in the practising of SFT that its true shape emerges, and that is conditional on qualities related to the practitioner as much as to the model itself; related to ways of thinking as much as ways of being. The issue of whether SFT is a strategic form of therapy might have continued to be debated if there had not been a wider paradigm shift (Kuhn, 1970) that created a change in thinking about how therapeutic endeavours work. By the 1990s, there was a new grouping of social constructionist strengths-based models of practice, influenced by advances in developmental psychopathology, in particular the construct of resilience (Rutter, 1987, 1990; Luthar, 2000), the development of the strengths perspective in social work (Saleebey, 1992, 1997, 2001), the emergence of concepts of learned optimism and hope in psychology (Seligman, 1991; Snyder and Lopez, 2002), as well as the less helpful generalization of a positive psychology movement (of which more later). Here SFT found a new home.

Constructivism, postmodernism, and social constructionism

That SFT is of a new generation of social constructionist models is now generally accepted. The interrelated ideas of social constructionism, constructivism, and postmodernism deserve some consideration with respect to their influence on the field of therapy.

Social constructionism views ‘ideas, concepts and memories arising from social interchange and mediated through language’ (Hoffman, 1990: 8), and as applied to therapy draws on the work of authors such as Kenneth Gergen and Michael Foucault. Wetchler (1996) proposed that four approaches, one of which is SFT, fit this category, being ‘based on the concept that reality is an intersubjective phenomenon, constructed in conversation among people’ (p. 129), identifiable by their adherence to four principles:

1. That reality is constructed in conversation, and that what we perceive as ‘real’ is often due to dominant beliefs within ourselves and society as we view the world through the lens of a succession of stories – personal and gendered but also influenced by community, class, and culture. As the concept of the ‘self’ is itself socially constructed, therapists do not have any special insights into individual or family life but are instead participants in constructing a reality with their clients.
The systems metaphor for describing families is rejected. The ability of therapists to objectively ‘diagnose’ families is challenged and so the systems metaphor that encourages therapists to take an objective stance is also rejected: ‘The concept of systems originally was used as a metaphor for describing families. Over time therapists began to view families as actually possessing those concepts’ (Wetchler, 1996: 131).

Therapist expertise holds no more prominence than client expertise. Drawing on work by Foucault, narrative therapists such as Michael White highlighted the issue of how psychological knowledge and diagnosis often reproduce dominant cultural values that serve to marginalize the wisdom of those who are socially excluded and viewed as outsiders. By reframing the therapeutic encounter as one to which each participant brings his or her own expertise, therapy is seen to become more ethically and morally sound: ‘By placing therapist knowledge above client knowledge, we not only further objectify and demean our clients, but we also close the door to new and possibly unique ways of viewing and solving client problems’ (Wetchler, 1996: 131–132).

Therapy is co-constructed between therapist and client. A balancing of therapist knowledge with client knowledge leads to therapy becoming less hierarchical: ‘The role of the therapist becomes one of opening doors for clients to explore new meanings in their lives. This means engaging them in a slightly different conversation than the ones they usually have around the problem’ (Wetchler, 1996: 132). Through this new dialogue, clients develop different ways of viewing their situation, and hence new ways of overcoming their difficulties.

As we shall explore further in Chapter 3 and the subsequent chapters on specific practice settings, this assertion has to be tempered with recognition of the role and responsibilities of workers in different contexts.

Constructivist ideas were introduced into the brief strategic field primarily through Watzlawick’s (1984, 1990) work, followed by specific features in family therapy journals in the later 1980s (Efran et al., 1988; Leupnitz, 1988). Constructivism has been defined as

an epistemological paradigm that has its roots in the writings of the Greek Skeptics . . . Constructivists view knowledge as actively constructed by the individual, and although not denying an ontological reality, ‘deny’ the human experience the possibility of acquiring a ‘true representation’ of reality.

(Gale and Long, 1996: 13)

‘The Inverted Reality’ (Watzlawick, 1984) drew together contributions from a number of constructivist philosophers, of whom the radical construct-
ivist, Von Glaserfeld, appears to have had most impact on both the MRI and the Milwaukee team (de Shazer, 1988, 1991). These ideas were introduced into the wider field of family therapy through the work of the Milan associates, especially Boscolo and Cecchin (Boscolo et al., 1987), and informed by the constructivist school of Maturana and Varela (1987). Constructivism has been viewed as most useful in its scepticism about the concept of truth: ‘When families, or families and professionals, are engaged in battles over “truth”, a constructivist frame that incorporates many different truths is invaluable’ (Burck and Daniel, 1995: 26). Taken in isolation, constructivism can be blind to potential ethical and moral issues in relation to what is observed; and if it leads to a privileging of subjective reality, risks minimizing or ignoring issues of oppression or abuses of power within and outside the therapeutic process.

Constructivist ideas brought about three important shifts in systemic thinking: the emphasis given to the functioning of the individual within the group and not exclusively to the collective phenomena of the system; greater attention was paid to the meaning that one person has for another and the cognitive, emotional, and relationship factors that bind them together; and the recognition that the presence of an observer changes the context of the observations and therefore modifies the nature of the information gathered (Reder et al., 1993: 26). Constructionism, on the other hand, ‘based on the concept that reality is an intersubjective phenomenon, constructed in conversation among people’ (Piercy et al., 1996: 129), is more grounded in a philosophy of community and relatedness.

Another important theoretical influence on de Shazer, which he incorporated more fully in his later publications, was postmodern philosophy. This had a broad impact on family therapy in its ability to provide ‘a framework within which to address differences and challenge polarities . . . while postmodernist ideas seem to reflect well the experiences of fragmentation and saturation that many individuals live in the modern world’ (Burck and Daniel, 1995: 29–30). Postmodernism could be problematic if it was interpreted as according all narratives equal status, and ignoring context: ‘i.e. our society, which neither confers equal validity and status on all views, nor provides the resources for all views to become established in practice’ (Burck and Daniel, 1995: 30). Solution-focused therapy is frequently categorized as one of three postmodern therapies (along with narrative therapy and collaborative language therapies) distinguishable by an attempt to minimize an authoritarian stance in favour of a more collaborative approach. Subsequently, integrated models drawing on different postmodern approaches have been developed, particularly in social work. Parton and O’Byrne (2000) outline a social constructionist framework for social work practice that incorporates both solution-focused and narrative concepts and techniques. Their constructive approach ‘emphasises process, plurality of both knowledge and voice, possibility and the relational quality of knowledge . . . An ability to
work with ambiguity and uncertainty both in terms of process and outcomes is key’ (Parton and O’Byrne, 2000: 184).

De Shazer can be said to have taken a postmodern stance on helping when he asserted that problems exist when clients acknowledge that there is a problem to be addressed; and problems are resolved when clients’ evaluations indicate that this is the case. This stance created some formidable distance between de Shazer and the evidence-based practice community, who distrust client feedback and evaluation as a sole source of knowledge.

Since the 1990s, the social constructionist paradigm has become more rather than less influential (McNamee and Gergen, 1992; Carr, 1995; Witkin and Saleebey, 2007). The effect it has had on brief therapists, some of whom started off using pure strategic models, is described thus:

We are now less certain, less audaciously tactical, less wedded to oversimplistic models, and far less impressed with our own cleverness. We have become more concerned with the resourcefulness of our clients and with avoiding approaches that disempower, either overtly or covertly. We have become more concerned with the development of a cooperative approach.

(Cade and O’Hanlon, 1993: xii)

Although the metaphor of a conversation may now be frequently used to denote therapeutic encounters, to signal the changes towards a more equal relationship between client and practitioner, and to indicate that both have contributions to make, there is a limit to how far the metaphor can be taken if the practitioner is also to fulfil his or her professional and ethical obligation to offer some expertise in how problems may be solved or solutions constructed. This point has now been acknowledged quite explicitly by de Shazer in a significant shift:

SFBT therapists accept that there is a hierarchy in the therapeutic arrangement, but this hierarchy tends to be more egalitarian and democratic than authoritarian . . . The therapist’s role is viewed as trying to expand rather than limit options . . . SFBT therapists lead the session, but they do so in a gentle way, leading from one step behind.

(de Shazer et al., 2007: 3–4, my emphasis)

In accepting that therapists use influence to help people change and use particular interventions to help them to do so, brief therapists implicitly restrict the extent to which the metaphor of ‘conversation’ can be used to depict the therapeutic encounter. The issue of how influence is used (and experienced) in work with vulnerable people is as much a preoccupation for frontline workers in health and social care settings as it is for therapists explicitly designated
to carry out psychological change-work. The development of anti-oppressive and anti-discriminatory frameworks for practice in health and social care (Dominelli, 1988; Thompson, 1993, 1998, 2003) evolved from a concern about how workers sometimes use their power in an oppressive manner. In considering the adaptations to the approach required for ethical practice beyond the clinic walls, such concerns will need not only to be recognized but will be addressed in Part Two.

Solution-focused therapy: a moving target

Solution-focused therapy is acknowledged by many as being one approach that has been adopted and applied in tremendously diverse ways, so that: ‘Any description of solution-focused therapy by outsiders will be, at best, a partial snapshot of a moving target’ (Shoham et al., 1995: 151–152). This theme was not only accepted by de Shazer but elaborated upon:

> We believe that it is useful to think about solution-focused therapy as a rumor. It is a series of stories that circulate within and through therapist communities. The stories are versions of the solution-focused rumor . . . Our goal is not to offer the final, definitive and only credible story about solution-focused therapy. We recognize that rumors belong to whole communities. No particular story-teller ‘owns’ a rumor.
> (Miller and de Shazer, 1998: 368, my emphasis)

That SFT continues to evolve is evident from the post-1986 publications of de Shazer and Berg and others. A more fitting description for this ‘moving target’ may be as a minimalist formula that is underpinned by a number of principles developed by other skilled therapists and which uses some simple strategic interventions, but does so within a social constructionist perspective and with a strong dose of hopefulness at its core. That it is indeed a hybrid is more proudly acknowledged by its originators now as they emphasize its inductive and practice-based origins: ‘SFBT is not theory based but was pragmatically developed. One can clearly see the roots of SFBT in the early work of the Mental Research Institute in Palo Alto and of Milton H. Erickson; in Wittgensteinian philosophy; and in Buddhist thought’ (de Shazer et al., 2007: 1).

Also of relevance is the increasing emphasis placed in recent years on the precise construction of questions and communication patterns. Payne (1997) places SFT in the category of practice models based on social communication theory. Kim and Franklin describe it as using carefully posed questions that purposefully use communication tools from communication science that change perception through co-
constructive language, combined with collaborative goal setting, and the use of solution-building techniques that occur between therapist and client . . . These carefully constructed communication processes are believed to be key components to helping client’s change. Solutions emerge in perceptions and interactions between people and problems are not to be solved solely by the therapist but rather solutions are co-constructed with the client(s).

(Kim and Franklin, 2009: 464, my emphasis)

As the model remains dynamic, it is more accurate to refer to the ‘family’ of solution-focused approaches, which are themselves increasingly seen to belong to a larger grouping (or ‘community’) of collaborative, language-based approaches. These are part of a generation of approaches to change-work based on the epistemology of social constructionism and premised on the philosophical position that the therapist is not an omniscient expert but a facilitator to the client seeking change.

While de Shazer launched his model in 1986 as a complete ‘prescription’ for therapy, this status is debatable. Modifications made since then both by the originators and those who have applied it in various settings suggest that most

<table>
<thead>
<tr>
<th>Box 1.3 Therapeutic principles (de Shazer et al., 2007)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Positive, collegial, solution-focused stance – positive, respectful, and hopeful</td>
</tr>
<tr>
<td>2 A search for previous solutions</td>
</tr>
<tr>
<td>3 Questions versus directives or interpretations</td>
</tr>
<tr>
<td>4 Present and future focused questions versus past-oriented focus</td>
</tr>
<tr>
<td>5 Compliments</td>
</tr>
<tr>
<td>6 Gentle nudging to do more of what is working</td>
</tr>
</tbody>
</table>

‘The therapist’s role is viewed as trying to expand rather than limit options’ (p. 4).

Underlying beliefs

1 The future is both created and negotiable: ‘With strong social constructionist support, this tenet suggests that the future is a hopeful place, where people are the architects of their own destiny’ (p. 3).

2 No problems happen all of the time – there are always exceptions to be utilized, and the three main principles are: ‘If it ain’t broke, don’t fix it’; ‘If it’s not working, do something different’; and ‘If it works, do more of it’.

3 The language of solution development is different from that needed to describe a problem: ‘The language of solutions is usually more positive, hopeful and future-focused, and suggests the transience of problems’ (p. 3).
commonly it is used as an approach consisting of three elements – a belief system, a set of principles, and an array of techniques – which are versatile and flexible and have proven adaptable across a range of problems and client groups and capable of being integrated with other approaches such as psycho-educational and cognitive-behavioural programmes.

Examples of the range of the approach include: residential child care in Australia (Durrant, 1993), groupwork with paediatric nurses in the UK (Goldberg and Szyndler, 1994), social work in child psychiatry in Ireland and the UK (Wheeler, 1995; Sharry, 1996), mature social work students in the USA (Baker and Steiner, 1995), adolescent and adult substance abusers (Berg and Gallagher, 1991; Berg and Miller, 1992b, 1995), Home Based Services for children and families (Berg, 1994), child psychiatry in Finland (Furman and Åhola, 1992), community care social work in Ireland (Walsh, 1995, 1997), generic social work practice in Finland and the USA (Sundman, 1997; Maple, 1998), counselling practice in the USA (Littrell, 1998), fostering social work (Houston, 2000), groupwork in Ireland (Sharry, 2001), child protection in Australia (Turnell and Edwards, 1999), child protection in the USA (Berg and Kelly, 2000; de Jong and Berg, 2001; Antle et al., 2009), and social work practice teaching in the UK (Bucknell, 2000). There are also texts that act as instruction manuals for the development of solution-focused skills (e.g. de Jong and Berg, 2008). This list is not exhaustive – and is supplemented by more detailed accounts of the literature relating to specific practice contexts in Chapters 4–8 – but it does demonstrate the extent of its appeal. Against this a range of concerns and criticisms has been voiced about the approach.

Critiques of solution-focused and brief methods

Some authors have taken issue with brief methods of treatment, others with cognitive approaches, and others with SFT itself. The more general critiques will be explored first and followed by those specifically concerned with SFT.

General concerns

Some British social work theorists deplore the rise of brief, focused methods of intervention linking them to the rise of a radical liberal perspective: ‘Clients arrive, in effect, without a history; their past is no longer of interest. It is their present and future performance which matters’ (Howe, 1996: 88–89). Howe believes that little attention is then paid to the construction and understanding of the client’s narrative:

Work is short-term, time-limited and ‘brief’ . . . There is no
accumulated wisdom because there are no psychological or sociological theoretical frameworks in which to order and store it. Each new encounter simply triggers a fresh set of transactions, negotiations and agreements.

(Howe, 1996: 90–91)

Howe maintains that this preoccupation with ‘surface’ rather than ‘depth’ prevents workers from understanding and appreciating the non-rational and distressed behaviours of people under stress and that this inhibits their ability to respond appropriately. Like Stevenson (1998), his concern is for those problems and client situations that he believes are not amenable to minimalist interventions. Taken in isolation, the original article by de Shazer et al. (1986) that launched SFT might give the impression that it uses the concept of ‘solutions’ to trick clients into thinking differently about their problems without any sensitivity or consideration for their subjective experience, and is narrowly focused on minimalist outcomes as Howe worries. If this were how it was practiced, it would raise major issues. The notion of persuading people that things are not as bad as they think clearly has to be tempered by an understanding of both the salient factors in people’s lives and of the need to express and process negative and strong emotions. Of relevance here also is the critique of ‘positive thinking’ recently issued by Ehrenreich (2010). In her book, entitled *Smile or Die: How Positive Thinking Fooled America and the World*, she asserts that the assumption underlying positive thinking is that you only need to think a thing or desire it to make it happen. She describes this practice as immoral, as it dupes people into thinking that they have control over aspects of their lives when they are in fact powerless. She relates this to the existing practice in the USA of hiring motivational speakers to ‘counsel’ people being made redundant that this catastrophe in their lives is in fact a golden opportunity, as so persuasively conveyed by George Clooney as Ryan Bingham in the film *Up in the Air*.

As outlined earlier, many SFT practitioners emphasize the quality of the relationship forged between worker and client, and focus on process. Lipchik (1994) notes that the most obvious clinical error of all when using SFT is to ‘focus on the technique and neglect the actual flesh-and-blood client sitting with them . . . in general, the choice of techniques should be driven by how a particular technique will serve and fit the client, not the therapist’ (pp. 37–38). Subsequent research on micro-communication (Beyebach and Carranza, 1997; Tomori and Bavelas, 2007) confirms the importance of following the client’s lead in establishing an active engagement.

Research studies outlined in more detail in Chapter 3 indicate that SFT in general is not normally used in a formulaic manner but has been most often thoughtfully combined with other approaches, and sometimes ‘re-invented’ to meet the needs of specific clients or client groups. In Chapter 3, the extent to which practitioners drawing on the SFT approach exercise sensitivity and
judgement in deciding when and how to use the approach will become more evident.

**Political concerns**

Objections to brief models of therapy have also been made on political grounds based on the legitimate fear that policy-makers and budget-holders ultimately restrict choice and therapists’ professional autonomy by imposing restrictions on the length and type of treatment. The introduction of ‘Managed Care’ in the USA and the curtailment on length of treatment funded by private insurance companies in Ireland and the UK illustrate that these fears are justified. The issue centres not on dismissing the real benefits that brief methods can offer but on promoting a deeper analysis of the complex nature of many problems, which acknowledges that short-term active change-work is not always possible or appropriate. Again, although not obviously explicated, the SFT model does caution against presuming that all clients are ready (or able) to work towards change – de Shazer (following on from the MRI team) emphasized the importance of assessing whether a client was a ‘customer’ for change or in another category. If the latter, other activities are needed to motivate people towards more active problem-solving.

**‘Grand claims’ concerns**

Concern has been expressed about the indiscriminate acceptance of the SFT model by some social workers and social agencies, ‘in spite of the dearth of empirical evidence for its claims to provide clients with more rapid and more enduring change than other treatment models’ (Stalker et al., 1999: 468). These objections have been echoed in the addictions field about SFT advocates (Miller and Berg, 1995) promoting ‘The Miracle Method’ as a radically new approach to problem drinking. This claim is viewed as excessive given that (at that time)

> not a single scientific evaluation has yet been published to support the ‘solution-focused’ counselling method that it described... [and] Desperate and vulnerable people deserve, and have a right to expect, a higher standard of professional responsibility and accountability.

(Miller, 2000: 1765)

Stalker’s and Miller’s objections to the approach stem from the exaggerated claims of some SFT proponents. That both critiques emanate from North America may reflect the lucrative and competitive nature of the therapy business there, but as British-based Edwards also notes:
People in that sort of situation [with addiction problems] are, however, immensely vulnerable to the blandishments which may be offered by any treatment approach which is marketed with large claims for efficacy and carries a public relations message which connives with expectations of a magic cure.

(Edwards, 2000: 1749)

Clearly, there are issues involved in exaggerated claims: claiming *anything* as a ‘miracle method’ is unethical.

**‘Insensitivity’ concerns**

Fook critiqued the growing development of strengths perspectives throughout the 1990s, which she maintains do not take account of the differing realities, vulnerabilities, and challenges that individuals experience over their lifetimes:

‘Progressive’ models of practice assume an ideal of ‘strength’ towards which the healthy personality works. Such views, however, do not take into account the changing contexts and historical times which all people experience in the course of a lifetime. In this sense, practice models may be far out of touch with the experiences of service users.

(Fook, 2000: 65)

The point she makes is that there is more complexity in human suffering than that allowed for in over-simplistic notions of solutions and strengths. In addition, the ideal of ‘strength’ may need to be more contextual than allowed for in generic models. Yet, complexity in appreciating unique suffering is also apparent in some SFT texts. As noted earlier, ‘coping’ questions are a central part of SFT developed to use where hope is missing or simple solution-work is not appropriate:

Like all workers, we encounter clients who are feeling hopeless and seem able to talk only about how horrible their present is and how bleak their future looks. Sometimes these clients are experiencing an acute crisis that gives rise to their hopelessness, and at other times the hopelessness represents a persistent pattern of self-expression and relating to others. In both cases, coping questions can be helpful in uncovering client strengths.

(de Jong and Miller, 1995: 733)
Feminist concerns

Dermer and colleagues’ (1998) feminist critique of SFT starts from the premise that such critiques can ‘identify gender and power imbalances and biases unintentionally perpetuated through therapy’ (p. 240). Drawing on one of de Shazer’s publications (1985) and comparing SFT to Leupnitz’s (1988) model of feminist therapy, they conclude that SFT fails in certain respects but in others is congruent with feminist ideals. Dermer and colleagues’ (1998) principal objections centre on:

(a) the concentration on behaviour change to the near exclusion of insight or explanation: a ‘tendency to overlook larger contexts within which families operate’ (p. 241);

(b) (the) adherence to notions of circularity leading to a rejection of the concept of blame as ever helpful. Making a distinction between ‘non-productive blame’ and ‘other-angered blame’ (the former obscures each individual’s responsibility and the latter identifies limitations placed on subordinate groups by dominant groups) Dermer et al. assert that both feminism and solution-focused perspectives ‘recognize that nonproductive blaming is not therapeutic, and both perspectives highlight responsibility . . . [they] agree on matters of personal responsibility but differ on the subject of blame’ (p. 242);

(c) the relativist tendency inherent in SFT. By placing a great emphasis on client-determined goals, it can be charged with taking a position of absolute relativism leading to unethical practice if no stand is taken to challenge damaging or dangerous goals. This possibility risks leading to a lack of attention to pressures inherent in unequal power relations, a consequent failure to engage in any thorough pluralist analysis (‘which examines the possibility that what is good for the family may not be what is good for an individual’ p. 243); and

(d) the ‘neutral’ therapist as advocated in SFT is more likely to unwittingly collude with existing oppressions. Dermer et al. (1998) are particularly critical of the espousal of a neutral stance in domestic violence, which while condemning the violence itself will make no move to advocate a woman leaving a violent partner, or to side with a woman against a violent partner. Yet Lipchik (1991) defends the use of SFT in ‘spouse abuse’, asserting that her priority is always the prevention of further violence, that therapy stops if the commitment to ending violence is breached, and that while she focuses on solutions that are ethical and consistent with clients’ own values, one of her own beliefs is that ‘sociopolitical issues must be addressed in some way in all cases’ (p. 63). The subsequent development of specific treatment programmes for spousal abuse (or domestic
violence as it is more commonly known in the UK and Ireland), such as that by Milner and Singleton (2008), which adopt a solution-focused approach within a clear ethical framework, indicates that advances in the practice model are possible which retain the integrity of the approach as well as incorporating a clearer ethical position.

Where SFT and feminist therapy do converge is on the position of the therapist and the value base of the approach. The feminist aims to adopt a position that is enabling and that values purposive self-disclosure as a starting point for emphasizing difference, and in this respect is roughly similar to solution-focused therapists. Solution-focused therapy is seen to be most congruent with feminist therapy in relation to the role of the therapist and the nature of the therapeutic relationship. Both advocate a collaborative relationship, clear therapeutic goals, and attention to the power of language. Dermer et al. (1998) conclude that while SFT uses methods congruent with feminist therapy, it falls short of feminist principles in its lack of attention to inequality and gender relations. They are correct in their identification of the lack of structural or gendered analyses within the original SFT theory. This weakness has been acknowledged from an early stage of SFT’s development by women therapists such as Lipchik (1991, 2002), Lethem (1994), and Dolan (1991), who have developed their SFT practices to include a more explicit ethical stance linked to feminist concerns.

The charge of being ‘apolitical’

A key issue in the feminist critique is how overtly or explicitly political the therapy process should be. For Dermer et al. (1998), as feminist scholars, therapy is viewed as a political process, and ‘as such, therapists should preserve their own beliefs while appreciating other positions’ (p. 243). Neutrality is seen as an unacceptable position because ‘failure to espouse one’s own beliefs and values may unintentionally reinforce the status quo. Clients may interpret neutrality as agreement with their political and personal views’ (p. 243). For de Shazer, on the other hand, it is unacceptable for the therapist to promote their own values and beliefs in sessions. He distinguishes between the goals of therapy and therapists’ personal orientations:

Therapists ask questions and make suggestions that are designed to help clients improve their lives . . . Therapists who fail at this job fail at therapy, no matter what else they may accomplish in the process . . . Therapists often use [certain] questions and answers to define therapy as a cause, and to assign different kinds of therapy to different causes. Stories about these issues are mostly told by therapists to other therapists. Thus, clients’ concerns and influence on the therapy
process are often minimized in these stories. Understandably, most clients have little interest in them. Why should clients care about the intellectual, political and other causes with which their therapists are identified? Clients have their own problems.

(Miller and de Shazer, 1998: 367)

Power and influence concerns

The development of more gender-sensitive forms of SFT, such as those described above, suggest that it is possible to combine the broad concepts of solution-focused therapy with anti-oppressive practice and a more explicit ethical position as required for helping professions in public services. Yet the case remains that unless the practitioner comes to SFT with an already developed sensitivity to gender and power issues, he or she will not find a framework for anti-oppressive practice in the original theory. It is only in more recent conceptualizations (Turnell and Lipchik, 1999; Lipchik, 2002; Macdonald, 2007) that an explicit acknowledgement of the importance of relationship and context has been developed. Lipchik (2002), for example, outlines how she proposes ‘a theory and basic assumptions for SFT that refutes the frequent accusation that SFT is formulaic and mechanical. It diverts emphasis from techniques to the therapist–client relationship . . . and to the use of emotions’ (p. 9). Her concern relates to areas that suffered neglect in the over-emphasis on a minimalist approach to therapy; also to the isolation of language ‘from the living human systems we are’ (p. xiv). Being reductionist in the description of a practice model is one matter, but tied to this is the lack of an analysis of the use of power and influence in the practice models we adopt. This is a point that I consider requires further emphasis and clarification for ethical practice in public services and so warrants a separate section in Chapter 3.

Conclusions

The ‘ideological currents’ that accompanied solution-focused therapy’s rise in popularity include:

1 Growing criticism of family therapy from feminists, clients, and others for its lack of attention to gender and power issues, the suggestion of ‘dirty tricks’ in strategic therapy, its lack of user-friendliness to consumers, and its lack of attention to outcome studies (Howe, 1989; Reimers and Treacher, 1995). Changes were needed if family therapy was to fulfil its potential as an ethical and effective practice.

2 The increasing importance of social constructionism and constructivism as epistemological influences in the postmodern era.
Solution-focused therapy is seen to fit the category of social constructionist models of therapy, and also ‘fits well in the present postmodern environment because of its emphasis on and belief in helping clients construct solutions that best fit their own lives’ (Mills and Sprenkle, 1995: 371). Given the range of criticisms that family therapy was attracting at the time, the appeal of SFT is obvious: it operates from principles that emphasize the client as a person of resources; it questions the assumption that the therapist knows best; and it redefines the role of the therapist as facilitator rather than expert.

3 The advent of managed care and budgetary restrictions to psychological therapies. Not only in North America but also in Europe, there is increasing curtailment of treatment lengths that both public services and insurance companies will cover, mainly due to the need to curtail ever-escalating health care expenditure. All brief therapies, not only SFT, stood to gain from this restriction of choice, although narrative and solution-focused therapies were seen to have an advantage as ‘postmodern approaches of established brevity’ (Mills and Sprenkle, 1995: 375). Debates about resource-led as opposed to needs-led decision-making and the curtailment of therapist discretion need to continue, but within a wider context – that therapy in itself is a very lucrative market and one which, some argue, in itself can be disabling and disempowering in its neglect of natural healing and spontaneous recovery phenomena (Furedi, 2004; Saleebey, 2008). To some extent, the contested claims and debates about SFT point to a phenomenon known as the ‘politics of theory’. This suggests that ‘proponents of particular approaches compete to achieve acceptance and status for their model’ (Payne, 1997: 3).

The philosophy of SFT is primarily humanistic with the emphasis on the client’s experience of the encounter and a strong belief in the potential of innate human resilience and resourcefulness. Solution-focused therapy shares with cognitive-behavioural therapy an emphasis on establishing small goals, use of scaling and self-assessment, the importance placed on the client’s view of the problem, and recognition of the often-disabling effects of stuck patterns of negative thinking, including hopelessness. Solution-focused questions are proposed as specific tools that can be used to develop the strengths philosophy (Saleebey, 1992, 1997, 2001, 2005, 2008) on a micro-practice level – with individuals, couples, and families: ‘It is hard to imagine a tighter fit between philosophy and practice than that between the strengths perspective and solution-focused interviewing questions’ (de Jong and Miller, 1995: 735).

The most significant criticisms of SFT have been:
of exaggerated claims for its effectiveness and the relative paucity of rigorous scientific studies to justify its superiority;

- of its omission of any structural or gender analysis of power relations within client systems and client–therapist systems and lack of attention to these in the therapy process;

- concerns about the assumption that brief therapies can resolve all difficulties;

- the danger of clients in need not being offered longer-term supports and interventions;

- the ethical problems that can arise if concepts of neutrality and pragmatism are taken too far without sufficient attention being paid to issues of influence and power; and

- the risks associated with a simplistic application of a positive psychology, which can in effect concentrate the focus on the individual experience, blame the client for wider societal ills that cause their problems, and imply that a simple cognitive shift can work miracles.

Some of the issues raised by these critiques can be addressed in the form of questions regarding practitioners’ use of SFT:

- Do practitioners use it to the exclusion of other theories and models?
- Is adoption of the approach wholesale or selective?
- Do practitioners use it primarily in a time-limited and performance-focused way?
- Are clients’ narratives ignored?
- Do workers try to use it to persuade clients that their troubles do not exist?

In Chapter 3, following an analysis of the ethical dimensions of practice in the helping professions in Chapter 2, an attempt is made to address these questions drawing on relevant research studies.