Part I

Theory and Practice

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A Theory of Solution-Focused Therapy

A solution-focused therapist felt stuck with a case and asked for help. He had had four sessions with John, a 46-year-old married attorney, with two teenage daughters, but after an initial report of improvement the solution seemed unclear. John had described his reason for coming to therapy as "being at the end of my rope in dealing with my widowed father." His brother-in-law, a physician, had suggested he ask his doctor for some medication, but John considered medicine a crutch.

John appeared extremely agitated during the first session. He was flushed, picked at one of his cuticles constantly, and spoke so rapidly that he had to stop and catch his breath at times. He related that his mother had died 5 months ago at age 75, leaving his 78-year-old father alone after 51 years of marriage.

John was one of four siblings, and the only one who lived in the same city as the parents. Since his mother's death, John and his family had made a special effort to be supportive to his father. At first this effort was appreciated, but as time went on his father became increasingly hostile and hard to satisfy. John's wife had urged John not to take his father's behavior so personally, but John was not able to avoid such feelings. The final straw had been when his father had refused to speak to him while on a visit to John's sister because "he didn't want to hear my voice." Since then, John had been unable to sleep or concentrate on his work.

John perceived that his relationship with his parents prior to his mother's death had been agreeable. He and his family saw John's parents at least once a week and spent all major holidays and birth-

days with them. Although the father had always expressed criticism more than praise, his mother's warm, nurturing ways had more than made up for it.

When the therapist had attempted to get John to define his problem and goals in behavioral terms, the best John could do was to say he wanted to learn to cope with his father's ways so he could be a good son. He recognized that he could not change an old man. He described his father's behavior toward him as "eating away my insides." He would know he was better when "his father's words would go in one ear and out another." John was unable to answer how his own behavior would change when that began to occur. The therapist had asked an exception question in relation to that goal: "Are there times when you already let your father's words go in one ear and out another?" John could think of only one example, shortly after his mother died, when he had felt very sorry for his father. The therapist tried to build on that exception by asking, "What was different at those times? What would you have to do now to make that happen, even a little bit?", but John was unable to answer.

The therapist then turned to another technique, the miracle question. "If you go to bed tonight and a miracle happens while you are asleep, and when you wake up in the morning your problem is solved, how will things be different?" John had answered that he would ignore the behavior. "Does that happen already at times?" the therapist asked. Not at present, said John. "What will you have to do to make that happen? Is there anything someone else could do to make that happen?" John said he felt he had no control at present to change anything.

At the end of the first session the therapist had composed an intervention message which complimented John for his desire to learn to cope with his father's behavior and for wanting to be a good son. It expressed empathy with John's difficult position, having to mourn his mother at the same time that he had to deal with his father's rejecting ways. The intensity of John's reaction was reframed as an unusually strong commitment to family. The therapist had also designed a task for John to give him a sense of control again. The task suggested that John give himself a break from being in touch with his father for 3 days as his father was being cared for by his sister. If, during that time, he ever felt comfortable about calling and wanted to do it to make himself feel good rather than to please his father, he could do so. However, if he felt ambivalent about calling, he was to remind himself that he did not have to make that decision until the fourth day. On the fourth day he was to call but talk

only to his sister and to tell her to tell his father he called to inquire about him.

When John returned a week later the therapist measured change by asking a scaling question: "On a scale from 1 to 10, with 10 being that you are as stressed as you can be, and 1 being that you are totally relaxed, where would you say you are today?" (de Shazer, 1991a, p. 148). John reported that his stress level had decreased from a 10 to a 7. He had chosen to call his father on the second day and had not felt as uncomfortable as he expected to even though his father had been short and unfriendly. Since then he had made one more call and also tolerated it better.

During the second session the therapist and John worked on reinforcing this increased comfort and tolerance John had described by discussing "What will have to happen for more of that to happen? What could you do? What could others do to help you?" The therapist also looked for resources from the past that could help John in the present situation by asking, "How have you dealt successfully with stressful personal relationships in the past?" At the end of the session the therapist complimented John on having gained some control in relation to his father and told him to continue doing what he had been doing.

During the third session John reported that his father had returned home. John had picked him up at the airport, and his father had immediately criticized John for not having been clear whether he would meet him at the gate or at the baggage claim. Since then there had been several difficult phone conversations that led John to feel his stress level was an 8 on a scale of 10 again. John repeated that he wanted to find a solution without medication.

In an effort to stay away from the problem and look toward a solution the therapist had revisited the exception that occurred between the first and second session. What was different then? John thought it might have been the fact that his father was in another city. It made him feel less responsible when his father was with his sister. At the end of the session John was given the task to pretend his father is in another city when he speaks with him over the phone. When he met with him in person he was to imagine his sister, or his brother in the room, as well. John did not report any improvement as a result of this task and appeared discouraged about his lack of progress.

Why was this case not progressing? The therapist was clearly doing solution-focused therapy (hereafter SFT) as it is generally understood. He had the client describe the problem and define a goal in behavioral terms.

Once John had described his problem, the therapist had used the exception question (de Shazer, 1985; Lipchik, 1988a), and the miracle question (de Shazer, 1988; Friedman, 1993; Lipchik, 1988a; Nau & Shilts, 2000). At one point, when the therapist was not getting any useful responses from John he had asked the coping question (Lipchik, 1988a): "How come things aren't worse? What have you done to keep things from getting worse?" This question often produces some strengths clients can build on, but it had not helped in this situation. The therapist had used the scaling question (de Shazer, 1991a) to measure change.

At the end of the sessions the therapist had offered thoughtful intervention messages and tasks that built on positives and made use of the client's way of experiencing the world, such as his need for control and his particular use of language. Why didn't any of these techniques lead to a solution for the client?

The answer is simple: SFT is more than the trademark techniques it is known for. It is a sophisticated therapeutic model that has been applied to a variety of situations such as adoption (Shaffer & Lindstrom, 1989), aging (Bonjean, 1989, 1996; Dahl, Bathel, & Carreon, 2000), alcohol abuse (Berg & Miller, 1992; Brasher, Campbell, & Moen, 1993), child protection services (Berg & Kelly, 2000; Turnell & Edwards, 1999), domestic violence (Lipchik, 1991; Lipchik & Kubicki, 1996; Lipchik, Sirles, & Kubicki, 1997; Tucker, Stith, Howell, McCollum, & Rosen, 2000), family-based services (Berg, 1994), multiple personality disorder (Barker & Herlache, 1997), physically impaired clients (Ahlers, 1992), residential treatment (Booker & Blymer, 1994; Durrant, 1993), sexual abuse (Dolan, 1991; Kowalski, 1987), school problems (Durrant, 1995; Kral, 1992; Metcalf, 1995; Molnar & Lindquist, 1989; Murphy, 1996), spirituality (Simon, 1996), children (Selekman, 1997), and more. SFT takes time and experience to master, just like any other therapeutic approach.

Perhaps SFT has been misunderstood because it was conceived as a minimalist way of intervening, a pragmatic way of problem solving (de Shazer, 1982, 1985, 1988, 1991a, 1994). Minimalism may have been interpreted to mean that all the therapist needs to do is to ask questions. Of course, that was never intended. At the Brief Family Therapy Center the prerequisite for trainees was a master's degree in a mental health discipline and 2 years of clinical experience. We expected people who were going to learn our model to be skilled in establishing and maintaining a therapeutic alliance. Unfortunately, we did not emphasize that in the literature but concentrated on describing the new ideas. I never realized

that misunderstanding until much later, when I showed a videotape at a seminar to demonstrate the use of questions as interventions. After watching for a few minutes a well-known colleague heaved a sigh of relief and said, "Oh, you contextualize those questions."

Although minimalism may have been misunderstood in practice, it did have a theoretical base and assumptions that offered guidelines beside questions. However, under the influence of postmodernism, theory was dismissed as antithetical to truly individualized treatment (Held, 1996, 2000). This new direction reduced SFT to "nothing but language"(de Shazer, 1994; Miller & de Shazer, 1998), another description that is open to misinterpretation. Language in postmodern theory is generally thought of in the broad sense

> as located in the consensual behavioral interactions between persons, not inside "the mind" of either. Rather than a vehicle that carries abstract communication back and forth between individual minds, it is a coordination of bodily states within members of a social group that preserves the structural integrity of both the social group and that of each group member. (Griffith & Griffith, 1994, p. 312)

Language is not intended to mean only the words people speak. However, even the broad description of language fails to guide therapists in using language to help clients find solutions. No wonder the solution-focused questions appear so attractive! They offer something concrete with which to work. The problem is that emphasis on form over substance usually does not give the desired results (Cecchin, Lane, & Ray, 1992).

The case of John, described previously, illustrates my point. The therapist used the basic techniques in the first session and had some positive results. When these changes were not sustained after the second session, the therapist continued to follow what he understood to be the right solution-focused direction. He tried scaling and coping questions to no avail.

To help this therapist get unstuck in consultation he was asked to think, "What is going on between John and me that might be causing this impasse?" He answered, "I am asking questions and giving tasks that are not making a difference. I have to do something different." However, he was perplexed about what that might be, given that he had used all the right techniques.

The next suggestion was to consider the following assumption: *Therapists can't change clients, clients can only change themselves*. How might that be helpful? The therapist answered that it made him think

more about what was going on with John, particularly about the death of John's mother. This therapist's message at the end of the first session is evidence that he was aware that John was in the midst of intense mourning for his mother. However, he believed that he should not talk about it with the client because, first, it would distract from talking about positives and the future; second, it dealt with John's emotions; and third, it had not been identified as a problem or a goal. When the therapist was encouraged to address the mourning it proved to be the key to the solution. John started to cry and to vent about how much he missed his mother. He spoke about how he never realized how much his mother had compensated for his father's personality, and how he had no idea how he would manage without her in the future. This outpouring of emotion prompted the therapist to put aside thoughts about intervention at the time and just to be supportive. Toward the end of the session John made a confession. He told the therapist that he felt more stressed from guilt than from anger at his father because he had been wishing all along that his father had died instead of his mother.

Notice how the therapist's shift from a formulaic concept of SFT to one driven by emotion and theory lead to a more trusting relationship in which John felt safe to confess his shameful feelings. When these feelings were not judged but understood and normalized, John expressed some relief. The therapist then wondered how John thought his guilt was affecting his tolerance of his father's behavior. John made the connection that the more hostile his father was, the more guilt he felt, and the more guilt he felt the less he could tolerate his father's hostility.

John's new understanding led to a redefinition of what he wanted from therapy. He now declared he would feel comfortable if he could reduce his guilt about his shameful feelings from the present level of 10 to below 5. Once John was clear about that he began to find behaviors that helped him. He talked to his wife about his feelings and discovered that she and their children had had similar thoughts. John also began attending church more regularly. He confessed to his pastor, who responded in a comforting rather than judgmental manner. As John's guilt decreased, his grief increased, resulting in a gradual acceptance of his loss. This made room for some empathy for his father and a new connection with him around loving memories about his mother. At the end of treatment, 6 months later, John reported that to his surprise his father was showing some signs of becoming softer. "From a position of true respect, techniques per se become superfluous, as action appropriate to this situation is generated from the simple act of paying attention to what is needed" (Simon, 1996, p. 53).

All good therapy takes place in the context of a trusting relationship. The specific manner in which the therapist guides that relationship is determined by his or her theoretical orientation. Thus a psychodynamic therapist, who is guided by assumptions that clients must develop insight to change, will make different choices in conversation with clients than will a behavioral therapist, who believes that behavior changes as a result of new learning, or reconditioning. If solution-focused therapists assume change occurs through language, and that is understood to mean no more than asking certain questions, disappointing results are probable (Fraser, 1995).

BEYOND TECHNIQUE TO THEORY

The suggestion that the road to the more successful use of a minimalist model is to complicate it with theory will undoubtedly seem paradoxical to some readers. Many clinicians, eager to improve their clinical skills, look for more ideas about "how" to talk to clients not "why." Workshop participants are eager for videotapes or live demonstrations of how the presenter works and may quickly become restless and bored with theoretical explanations. Theory is an abstraction that appears, at times, to be far removed from the actual conversations we have with clients. However, it is the only solution to a problem many therapists struggle with but are reluctant to admit that they have, namely, that they often sit in a session and do not know what to do next.

Theory becomes less formidable when we realize that it is part of everything we do well in life. Driving a car safely requires some theory that goes beyond obeying traffic signals. Playing tennis, golf, sailing, and other sports entail theoretical assumptions about our bodies and the physical properties of the air around us. Good cooking is more than following a recipe. It requires assumptions about what will happen to certain foods when they are subjected to heat, or when they are mixed with each other. Of course, people can do all these activities without understanding the underlying theory, but it is less likely that they will excel at what they do or transcend technical skills to become artists. Because therapy is a professional endeavor that brings with it a huge responsibility toward other human beings it is worthy of our best efforts.

This book 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, so important for successful outcome (Bachelor & Horvath, 1999; Beye-

bach, Morejon, Palenzuela, & Rodriguez-Arias, 1996; Hubble, Duncan, & Miller, 1999) and to the use of emotions. Less attention to techniques helps therapists avoid two common pitfalls: withdrawing attention from clients to ruminate about what question to ask or asking the questions at inappropriate times.

A BRIEF HISTORICAL DETOUR

SFT was originally conceived as Brief Family Therapy in Milwaukee, Wisconsin, in the late 1970s (de Shazer, 1982). As such, it can be thought of as a younger sibling of the brief therapy model developed at the Mental Research Institute in Palo Alto, California (Fisch, Weakland, & Segal, 1982; Ray, 2000; Watzlawick & Weakland, 1977; Watzlawick, Weakland, & Fisch, 1974). The Mental Research Institute model has roots in the work on paradox and human communication led by Gregory Bateson (Bateson, Jackson, Haley, & Weakland, 1956; Jackson, 1959) and Milton Erickson's ideas about circumventing resistance in hypnotherapy (Erickson, 1977; Erickson & Rossi, 1979). However, while the Mental Research Institute's interventions were targeted at interrupting interactional patterns therapists identified as faulty attempts at solution, the Brief Family Therapy Center's ecosystemic approach (de Shazer, 1982; Keeney, 1979) was more collaborative, and based on the assumption that "the family has the solution" (Norum, 2000). Therapists together with clients were considered a therapeutic suprasystem that generated new, nonproblematic interactional patterns for the family system. This mind-set was more in the tradition of the postmodern era that followed, in which constructivism and social constructionism[1] became dominant influences in the field of family therapy.

The shift from problem-focused Brief Family Therapy to SFT occurred in 1982, in a random manner. As I remember the incident, there

1. "Constructivism" is defined here as "a relativistic point of view that emphasizes the subjective construction of reality. [It] implies that what we see in families may be based as much on our preconditions as on what's actually going on" (Nichols & Schwartz, 1995, p. 590). It is represented by theorists such as Paul Watzlawick (1984), Humberto Maturana (1980), Heinz von Foerster (1981), and Ernst von Glasserfeld (1984). Each person constructs his or her own image of what reality is through language (Anderson, 1997). "Social constructionism" (Gergen, 1982, 1991, 1994), with which constructivism is confused, goes a step beyond this to assert that individual constructs are shaped entirely through conversations with others.

were a number of core group members behind the mirror formulating an intervention message for a family that had come with their rebellious teenage daughter and was not reporting any progress by the end of the second or third session. The father and mother were only interested in reporting all the things their daughter continued to do wrong and diverted from any questions about exceptions. The daughter remained sullen. That day, one of us behind the mirror—and there are strong opinions about who it actually was—said, "Why don't we ask them to make a list of what they *don't* want to change for next time?" We all agreed, and were pleasantly surprised when the parents and the daughter came back with sizable lists of what they appreciated about each other. What was more surprising, however, were the positive changes all three family members reported. They all agreed that there had been less tension in the home. The parents felt their daughter's attitude had changed for the better and the daughter felt that her parents had stopped being so critical. After assigning this task to the next few clients at the end of the first session and getting similar results, a research study was designed (de Shazer, 1985, p. 147). The results indicated that the concrete changes clients reported in the second session generally had little to do with their description of the problem or complaints in the first session. Moreover, these changes could often be amplified to become solutions. This discovery shifted our attention to the interview as a locus of intervention (Lipchik, 1988a, 1988b; Lipchik & de Shazer, 1986; Penn, 1982, 1985; Tomm, 1987a, 1987b). The message and task at the end of the session now reinforced the process that was generated during the interview. Gradually, these future-oriented, solution-focused questions overshadowed all else that was essential for conducting good therapy, particularly the emphasis on cooperating with how clients cooperate, which is defined as follows: "each family (individual or couple) shows a unique way of attempting to cooperate, and the therapist's job becomes first to describe that particular manner to himself that the family shows, and then, to cooperate with the family's way" (de Shazer, 1982, pp. 9–10).

In an effort to conserve this relational/interactional context for the techniques in a theoretically sound manner (Lipchik, 1993), I revisited the interpersonal theory of psychiatrist Harry Stack Sullivan (Chapman, 1973; Sullivan, 1953c, 1953d). Sullivan's thinking fit the constructivist frame (Cushman, 1995) because it denied objective reality in therapy, except for what can be "directly observed (in the present) in the context of interpersonal relationships [the therapeutic relationship]" (Chapman, 1973, p. 70). Consequently, Sullivan defined the therapist's role as that

of a "participating observer" (1953d, p. 18) whose job was to engage with patients in a process toward more functional interpersonal behaviors rather than to sit silently and interpret. Diagnostic labels also did not fit Sullivan's thinking. Problems and solutions were no more or less than an individual's degree of emotional discomfort ("anxiety") or comfort ("security") in interpersonal relationships. Like Maturana and Varela (1987) much later, Sullivan (1953d) considered these human relationships from a biological perspective, an interdependence of living organisms with their environment.

In 1984, the Brief Family Therapy Center engaged in a project in artificial intelligence—"BRIEFER"— to develop an "expert system," a computer program to assist in formulating a task in the first session (Goodman, 1986; Goodman, Gingerich, & de Shazer, 1989). For that purpose, we engaged in a step-by-step analysis of how we made decisions in relation to clients, both as the interviewer and team member behind the mirror. This exercise really illuminated the importance of nonverbal language and emotions as a context for, and connection between, questions and answers. Yet it stimulated the development of a theory of solution (de Shazer, 1988) that was essentially a decision tree for the solution-focused therapeutic process. In retrospect, this further depersonalization of SFT spurred me on to counter this trend (Lipchik, 1993, 1994, 1997, 1999; Lipchik & Kubicki, 1996). My search for a theoretically sound way to do so continued after I left the Brief Family Therapy Center in 1988 and started ICF Consultants, Inc., with Marilyn Bonjean, in Milwaukee.

The theory of cognition developed by the Chilean biologists Humberto Maturana and Francisco Varela (1980, 1987; Varela, 1989) that stimulated the field of family therapy in the early 1980s (Dell, 1982, 1985; Efran & Lukens, 1985; Efran, Lukens, & Lukens, 1990; Ludewig, 1992; Parry, 1984; Simon, 1985) eventually provided the basis of a suitable framework. Maturana himself has describes this theory as a "metatheory," which provides a way of unifying all the disparate theoretical schools of family therapy (Simon, 1985, p. 4).

In studies of the retina of frogs conducted in the 1950s, Humberto Maturana discovered that the image a frog's brain received when visualizing a fly is the result of the structure of its eye, not an objective representation of the fly in the world outside. This discovery had a considerable impact on the understanding of perception and eventually led to a theory of cognition (1980, 1987) that suggests that our reality, or what we know, depends on who we are in terms of our structure, as well as our interactions with others.

Maturana and Varela's theory describes living systems as "autopoietic," organized to survive and re-create themselves. This survival and re-creation depends on structure coupling, a state of interdependence with the environment and/or other living systems. Mutual survival is constantly challenged by internal perturbations as well as mutual external perturbations and depends on mutual adaptation. Perturbations cannot change another living system; they can only trigger the possibility of change. That change depends on the particular organization of the system (structure determinism). Thus, if two or more interdependent systems cannot conserve their basic survival needs in interaction with each other, their relationship will end. For example, if the heart fails it will destroy the respiratory system, the vascular system, and the renal system and a person will die.

According to this theory, the development of language occurred late in the evolution of living systems and distinguishes humans from other living mechanisms. Language is seen as part of a person's individual structure but a mutually dependent action, "a phenomenon that takes place in the recursion of linguistic interactions—linguistic coordinations of linguistic coordinations of action" (Maturana & Varela, 1987, p. 211). In other words, each human being has a closed neural network that generates its own information (Efran et al., 1990, p. 67), but language is an act of mutual adaptation, or consensus about meaning between people and social groups.

If I go to a restaurant and order a sandwich on toasted bread, I already have information in my system about what toasted bread means from previous linguistic interactions. I may have learned what "bread" and "toast" means from my mother when I was a little child. If the waiter in the present situation does not understand what toasted bread means we have to act to coordinate the meaning. Another way of saying it is that we have to adapt to each other in a way that our relationship can survive: that the waiter can fill my order in a manner that will satisfy me, and thereby fulfill his job in a way that will not get him fired. The coordination of the meaning of toasted bread depends on whether we both speak the same language. If we do not, can we understand each other in some other way, perhaps with gestures or nonverbal cues? If we both speak the same language but the waiter is not familiar with toasted bread, will I be able to explain it, and will he have the capacity to understand my explanation so we can maintain a mutually beneficial connection?

There were two aspects of Maturana and Varela's work that were particularly attractive to me as a solution-focused therapist. One was the idea that survival and adaptation is an interdependent process between

living systems that is based on conserving what these interdependent living systems need individually to survive; in other words, it is essential to build on what is working. The other was that we cannot know or act without biological dynamics we call emotions. In particular, the emotion Maturana and Varela (1987) call "love," or the acceptance of another beside us in our daily living, is considered the biological basis for social life that allows for the continuation of relationships and of life itself. This strength-based idea is strikingly similar to Harry Stack Sullivan's concept of "consensual validation" whereby people "attend to one another's emotional states and exchange coded information regarding what is proper and improper, anxiety provoking or soothing" (Cushman, 1995, p. 178).

A SOLUTION-FOCUSED THEORY

What follows is a theory that grew out of my personal experience of what works in SFT. I think of it as a constructivist theory that conserves some interactional/strategic concepts and integrates them with a biological perspective that includes emotions.

> *Human beings are unique in their genetic heritage and social development. Their capacity to change is determined by these factors and their interactions with others. Problems are present life situations experienced as emotional discomfort with self, and in relation to others. Change occurs through language when recognition of exceptions and existing and potential strengths create new actions.*

The assumptions made from this statement shape the therapist's attitude toward clients and guide the therapist–client relationship. Notice that these assumptions often overlap, or flow into each other even though they address different points. Thus, they have a way of reinforcing each other.

SOLUTION-FOCUSED ASSUMPTIONS

1. *Every client is unique*. This relates to the theory that living systems (clients) are structure determined. When solution-focused thera-

pists keep this in mind, it helps them resist the natural temptation to think that they know what the solution should be for a particular client's problem because it worked in a similar case, or because it works for them in their personal life. Because every client is unique, every relationship is unique. One couple's relationship problems after the birth of their first child may be solved when the wife allows the husband to participate more in child care while another's solution may be that the husband and wife each has an evening out once a week.

SFT is a constructivist model. Considering the use of the same intervention is a linear way of thinking that implies causality and focuses on content rather than process. The best way to ensure the probability of the fastest and most fitting solution for clients is to treat them as unique and to remain "curious" (Cecchin, 1987).

Of course, this is not meant to imply that personal or professional experience does not have a place in therapy. However, it should only be applied after we have tried everything we know to help the client access his or her own information, and then in a tentative manner, like "Some people find that it is helpful to . . . " or "If you were to consider . . ., do you think that could be helpful?"

2. *Clients have the inherent strength and resources to help themselves*. This assumption represents the heart of the solution-focused philosophy and is perhaps one of the most difficult ones for therapists to remember. As members of the helping profession we consider it our responsibility to relieve our clients' pain as quickly as possible. We become not unlike protective parents who guide too much in an effort to prevent their children from getting hurt instead of helping them to use their own resources to take care of themselves. Such parenting does not empower and build confidence!

Maturana's answer to the question "What is the purpose of therapy?" offers a helpful perspective to support this assumption. With regard to structure coupling, he said that therapy should generate dynamics of interaction in which people recover something in themselves (self-respect, love, legitimacy) as well as in others (1996). Considered from the position of therapists, it suggests we look for and emphasize our resources of acceptance, empathy, and respect for clients.

From a more practical point of view, this assumption is a reminder that the simple act of being alive and finding their way to our office represents clients' strengths. They have survived physically and emotionally so far, and we must now join them in continuing their life to the best of

their ability. However, the story of that survival can often be so fraught with difficulties and pain that it can make us feel devastated and hopeless. At those times, thoughts of "This is horrendous," "I can't be helpful here," or "I wouldn't know where to begin," are best counteracted with the assumption that clients have the strengths and resources to help themselves. This thinking then automatically leads to a response such as, "You really have a lot to deal with right now. How have you been coping with all this?" This response focuses on resources immediately as well as benefiting the therapist–client relationship with its message of understanding and positive regard.

3. *Nothing is all negative*. This assumption is supported by Maturana and Varela's idea that there can be no change without conservation. Our clients usually perceive their situation as all bad, and they are not aware of exceptions and their own resources. They say things such as "I must get rid of my anxiety" not realizing that some anxiety is an asset in many situations. As therapists we, too, are not immune to this either–or thinking at times. Thus, when clients present us with situations that involve personal losses, poor health, financial struggles, and legal problems all at once, which they sometimes do, this assumption directs us toward thinking, "Yes, but what has kept them going and how can we preserve that and build on it?" This thinking directs us toward coping questions, which are much more empathic and sensitive in extreme situations than to ask, "What's still OK in your life?" when nothing seems to be.

4. *There is no such thing as resistance*. "Resistant" is what therapists call clients who do not accept the therapist's point of view about how they should change. The whole concept of therapists labeling clients' behavior does not fit with SFT or postmodern thinking in general. A client cannot be resistant; the therapist simply does not understand how to trigger (perturbate) change in a way that allows the client to respond adaptively. Therefore, the therapist must continue to look to the client for better understanding of what will work for him or her.

Maturana uses the term "orthogonal interaction" to describe the therapeutic process. It means relating to a person in such a way that he or she must generate a new or infrequently used response. The interaction perturbates in a way that forces new patterns to emerge (Efran & Blumberg, 1994).

However, though resistance is not a fitting solution-focused con-

cept, the word "resistance" is still a good description of what solution-focused therapists often feel in interaction with clients. What therapist is not familiar with the experience of feeling his or her body tense as a client replies with "yes, but!" to everything that is discussed? We notice that we are not sitting back in our usual relaxed position but leaning toward the client stiffly. Our voice may be louder than usual and our throat may feel tight. We feel as if we are working too hard. If we can call on this assumption at such a moment it will help us sit back in our chair, take a slow breath, and turn to the client and ask, "What do you think would be best for you at this time so things can get better?" This is helpful for us, as well as for the client, because of the positive effect it will have on the emotional climate.

5. *You cannot change clients; they can only change themselves.* Once in a rare while, every solution-focused therapist experiences the feeling of being in a power struggle with a client, or of trying too hard to get an idea across. The belief that living systems are "informationally closed" and cannot be changed from the outside supports this assumption that prevents, or corrects, such lapses.

An example that comes to mind is a situation in which a mother, whose son was placed in residential treatment after sexually abusing a younger sibling, was ordered to work with a family therapist toward reunification. The boy was making excellent progress and the agency purchasing the services was anxious to have the boy discharged from the expensive residential treatment. However, in spite of solution-focused techniques the family therapist could not get the mother to stand behind her stated intentions to make the necessary changes in the home, and herself, so the home would be pronounced safe for the younger sibling. Colleagues he consulted urged the therapist to stop being "solution focused" and to intensify the mother's anxiety about losing her son to get her to change. Instead, this therapist chose to look back to some solution-focused literature from the late 1980s, and ran across this assumption. As a result, he decided he would change himself to make a difference. He decided to assume responsibility by apologizing to the mother for not having been helpful enough for her to meet other people's expectations for her and asked her to help him understand more about how he could do that. In response, the mother became very emotional and expressed some ambivalence about reunification. She confessed guilt about not wanting to make efforts to make changes that she believed had little chance of working. This confession opened up the op-

portunity for the therapist to help her deal with her guilt and work on some other options for the future that offered more hope. The boy was placed in foster care while the family continued to work toward reunification. An environment that indicated support, rather than blame, gradually led to changes that allowed for reunification.

When clients seem stuck it is often helpful to convey to them that we understand their feelings. Maturana cautions against trying to change clients by means of logic without a mutual agreement about the underlying emotions because of his belief that preferences (emotions) determine actions (Maturana, 1988, p. 17).

6. *SFT goes slowly.* SFT is a brief model, similar to the one developed at the Mental Research Institute Brief Therapy Clinic. I have dropped the word "brief" deliberately to dispel false assumptions. The foregoing assumption was originally developed to counteract the belief that "brief" implies "quickly." Brief therapy models can usually provide effective, long-lasting treatment in shorter periods than other therapy models. However, the brevity will be the result of the best-fitting intervention for a particular client, not speedy application of technique. Premature use of technique can prolong treatment because it may focus on complaints that are not related to what the client really wants from therapy.

SFT is also used slowly for cases that require therapeutic support for years. Episodes of intense contact during crisis interspersed with mild ongoing support can yield surprising improvement in functioning over time if the focus remains on small goals identified by clients and worked on in a secure emotional climate.

This assumption is primarily a reminder to us to be patient with ourselves. We are doing SFT even if we are just tending to the environment clients need in order to change.

7. *There is no cause and effect.* The concept of cause and effect does not exist in a constructivist world because it implies the existence of some objective truth. Instead, problems and solutions are viewed as the unpredictable events of living. Thus, we must not allow ourselves to be seduced by clients to join them in thinking "why does this problem exist?" but direct our efforts toward "What has to be different in the future?" On the other hand, we must be prepared to join our clients in talking about cause and effect if that is the only way they can think about solution.

For example, a client reports that a self-help book she read last week is responsible for her suddenly feeling like her old self again after several months of feeling depressed. The therapist's experience has been that she has reported gradual signs of improvement but has been reluctant to admit to them. What is important here is that the client found a way to change. If the client prefers to believe the cause of her change is a book rather than therapy, that cause-and-effect thinking is the client's way of changing and needs to be accepted. For this client, change in the context of a relationship with a therapist was not an option at that time.

There are some strong beliefs in the mental health field that the experience of sexual and physical abuse are directly responsible for emotional problems in later life. Undoubtedly, such terrible events have an impact on the victim's life; however, it is impossible to determine a direct link because one can always find clients who exhibit similar symptoms without having been abused. As long as mental health professionals do not have diagnostic tools like physicians, such as imaging techniques and blood analyses, cause-and-effect thinking is a road no solution-focused therapist should travel.

When clients search for causes it is useful to ask them how knowing the cause will be helpful for them in solving their problem. They usually say it will help them understand. The question, "If you could solve your problem without understanding, would that be all right?" usually offers another perspective that many clients have never considered.

8. *Solutions do not necessarily have anything to do with the problem*. This assumption was developed at Brief Family Therapy Center in 1982, as a result of the shift from problem to solution focus, described earlier. At the time, it was discovered that the question "What don't you want to change about the situation that you came about" generated positive differences outside the problem description. It seemed to trigger creative actions in clients who were unable to change when they thought about what they wanted to change.

Again, we are reminded not to think cause and effect. In life, like in therapy, change is inevitable as well as unpredictable. For example, a man or woman who is bored on the job may become increasingly lethargic and ineffective. An unexpected stimulus outside work, such as a hobby, sport, or new relationship, may result in a general change of attitude that affects his or her perception of and performance on the job as well. Searching for solutions only in relation to the problem can seriously constrain progress.

9. *Emotions are part of every problem and every solution*. For theoretical and practical reasons the Mental Research Institute and solution-focused model have had a cognitive-behavioral focus and eschewed talk about feelings except for joining. However, if language is thought of as an action from which emotion is inseparable, then clients emotions are as much a subject of therapy than their thoughts and behaviors. Given that theory, the failure to talk to clients about their feelings, and to connect with them on that level, could limit our understanding of them, their understanding of themselves, and the possibilities for solutions.

This assumption reminds us that emotions are part of language and are essential for our clients' process of decision making (Damasio, 1994; Maturana & Varela, 1987). This assumption also reminds us to be attentive to the emotional climate in which our relationship with clients takes place (see Chapter 2, this volume), first, because security, rather than anxiety, is the emotional state people seek (Sullivan, 1953d) and are most relaxed in, and second, because a state of relaxation makes people more open to their own resources and new information (Erickson, 1977).

If a client describes being stuck with his doctoral dissertation in engineering in terms of time, space, family obligations, and computer problems, the best way to cooperate with him would probably be to use language and concepts that fit his concrete world view. However, if that does not make a difference for him, introducing talk about his emotional state given the problem would be productive.

We connect with people emotionally in a nonverbal way as well, and some clients may be aware of their emotions but are more comfortable not talking about them. As therapists, it is our responsibility to be sensitive to our clients' comfort levels and to respect them. However, the important point is to convey that we understand what they are telling us in as much depth as possible.

10. *Change is constant and inevitable; a small change can lead to bigger changes*. The Mental Research Institute and SFT have always viewed problems as the inevitable ups and down of living. Some people overcome their problems by going to therapy and others recover spontaneously (Bergin & Lambert, 1978). Forty percent of clients are believed to recover because of extratherapeutic factors (Lambert, 1992). We really have no proof that those who seek help would not have improved without that help.

Our lives are subject to constant change given our complex network of relationships ranging from our nuclear family to people across the globe and circumstances such as wars, weather, and astrophysical phenomena, many of which are beyond our control or unknown. Change in any of them has the potential of affecting our lives.

An awareness of this certainty about uncertainty, combined with the belief in clients' inherent resources, helps the solution-focused therapist maintain a hopeful attitude regardless of the difficulties clients relate. Thus, when we feel overwhelmed by a client's story and feel as stuck as the client about what to do, the first step is to realize change is inevitable; the second step is to engage with the client about doing something, no matter how small, that the client thinks will make a difference. In a situation that appears hopeless or overwhelming, a small step can provide a sense of control that has been missing. Taking action, no matter how minor, can feel like movement out of total stuckness, and therefore it generates hope. It is up to us not to be too ambitious about our clients' small steps, and to keep the clients from being too ambitious, because something as seemingly insignificant as combing one's hair differently, making a phone call to an old friend, or eating a meal with someone rather than alone can lead to bigger changes.

All of us have had the experience of being overwhelmed with so much work that it seems too much to tackle. The best solution is usually to make a list, prioritize, and beginning working. Suddenly the entire workload seems manageable. A small change can lead to bigger change!

11. *One can't change the past so one should concentrate on the future*. This assumption is so self-evident and yet not easy to remember at all times. Accepting the assumption that language is an action in the present supports the belief that change can also happen only in the present.

Clients often say they will know they do not have to come to therapy anymore when they understand their past actions that resulted in the problem. They seem to believe that insight is necessary for a solution. Some clients even persist in trying to understand "why" after they have reached their goal.

A common occurrence in couple therapy is that even though both partners want to stay together they are held back from progress because one or both keep harping on hurtful events from the past. Solution-focused therapists must avoid getting caught in that futile process and find ways to help clients forgive, if not forget, for the sake of their future.

Another no-win process that frequently occurs in therapy is that clients obsess about the wrongs they perceive their parents to have perpetrated against them when they were children. Not only can these wrongs not be changed, but they may be memories of childhood perceptions that might have been experienced differently at another stage of life.

A useful way of working with clients who persist in harping on the past is to say "I realize that it is difficult for you to forget (or forgive) the past (pain, disappointment, etc.), but what do you think you would need now, or in the future, to come to terms with the fact that it happened, or to begin to put it behind you?"

Assumptions shape our attitudes toward clients and therefore our relationship with them. They help us make decisions about what to do. The assumption that clients have strengths will make us ask questions about them. The assumption that all problems and solutions involve emotions will remind us to be empathic and encouraging. When a client reports a relapse after several good weeks we may be tempted to join him or her in searching for reasons why this happened. Instead these solution-focused assumptions provide a source for shaping a positive attitude in us, and our clients, by prompting us to ask: "Since you first described the problem you came in about you have made some progress. This cannot not have had some effect on the present situation. What is different about the situation now than when you first came in?" These connections between theory, assumptions, and practice will be pointed out throughout this book.

CONCLUSION

As SFT has become increasingly atheoretical the skepticism, particularly about how it is practiced, has grown (Efron & Veenendaal, 1993; Kleckner, Frank, Bland, Amendt, & Bryant, 1992; Lipchik, 1994; S. D. Miller, 1994; Nylund & Corsiglia, 1994). The theory described in this chapter was developed to provide an alternative way of conceptualizing and practicing SFT, one that leaves less questions about its legitimacy and worth (Cecchin, Lane, & Ray, 1994). In keeping with the idea that change must involve conservation, this version of SFT reintroduces past aspects of SFT and integrates them with formerly unrelated ones. The biological component paves the way for integrating future findings from neuroscience and other medical areas that can help us help our clients more effectively.

I have based my reasoning about misconceptions about SFT on theoretical changes, but I want to emphasize that managed care companies should not be relieved of some blame too (Hoyt & Friedman, 1998). The endorsement by managed care companies of SFT as the brief treatment of choice resulted in a plethora of 1- and 2-day workshops designed to give the participants something useful to take back to their practice. In such circumstances, techniques take precedence and theoretical context only complicates matters. As these trainings proliferated, their main sound bytes have come to define SFT.

As therapists we should not expect our work to be a smooth ride. Therefore, we must keep searching for ways to cushion that ride for our clients and ourselves.

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