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THE SMALLEST SOLUTION FOCUSED PARTICLES: TOWARDS A MINIMALIST DEFINITION OF WHEN THERAPY IS SOLUTION FOCUSED

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This article addresses our difficulty with varying definitions of Solution Focused Brief Therapy (SFBT). On the one hand it is defined by a minimalist philosophy of doing whatever works for the client and on the other hand it is defined by use of key techniques such as the miracle question. We discuss whether or not the requirement for us to do what makes sense for each client may bring us into conflict with the technique-oriented definitions of SFBT.

In this theoretical article we are considering the confusion between identifying Solution Focused Brief Therapy (SFBT) by the use of key techniques and specified time frames on the one hand, and identifying SFBT by the major tenets of the approach which, in our clinical experience, can be evidenced without necessarily relying on the text of key techniques. We wish to galvanize a discussion about how solution-focused practitioners will know when a consistent definition of SFBT has been achieved that will capture what this approach looks or sounds like in a reliable way. We suggest here that this definition will need to focus on the individual nature of the work, such that it becomes a viable choice for individuals whose unique views of what works for them can be heard and utilized in SFBT even if the traditional questions are not useful.

We begin by reviewing some of the early writing, which suggests inconsistencies between technique-driven and client-centered SFBT during the development of this therapeutic approach. We identify the central beliefs that underpin this

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approach with particular attention to the possible conflict between the expectations that the therapist will privilege the client's language at the same time as using the language and time frames of key techniques. We follow this with the unique role of the therapist in solution focused therapy. We list the key solution-focused techniques that have come to represent SFBT, with particular attention to how the requirements for use of these techniques vary within a sample of research definitions. We then underscore our difficulty in using the key techniques within the required time frames with our clinical population of people who have developmental or acquired differences in their ability to take in, store, find, and use new information. In the final section we make a modest start at identifying the smallest possible particles, or indicators, that a therapist and client are doing SFBT.

Why is this Important?

As practitioners, trainers, and writers steeped in the effectiveness of SFBT, we are driven to be able to identify what it is that makes our work uniquely solution focused. We see the differences in how SFBT is defined for research purposes as a confusing combination of asking set questions alongside keeping close to the frames of reference that make sense to the client. Our experience is that doing one may interfere with doing the other. We note a small body of evidence, both in the literature and in our own work, that suggests key typical techniques are not consistently used in practice, which makes it difficult to tie actual clinical practice into the larger body of research within the field.

We further see that the solution-focused emphasis on learning what works from the individual client makes this approach an attractive option for people who may otherwise struggle to establish a useful relationship with a therapist. At the same time, these may be the very people for whom set texts and time scales are unhelpful. We are thinking mainly of our cognitively impaired clients, though we have also worked with cognitively intact therapy veterans who were only interested to work within their own frames of reference and for whom the typical solution-focused techniques were not useful. *Even without the use of key techniques, we feel strongly that we* are *"doing" solution focused brief therapy*.

We also think this confusion is important to discuss because some of the typical solution focused techniques, such as goal setting, use of scales, finding exceptions, and giving compliments are not unique to SFBT. We find technique-driven therapists who advertise their work as solution focused because they use these techniques. We find therapists who "use a bit" of solution-focused therapy, by which they mean they use some of the techniques. Our concern, borne out of being trainers and supervisors of the approach, is that these practitioners are using the techniques without an understanding of how to co-construct meaning or how to hear and take seriously the things a client says. Therapists can thus appear solution focused whilst at the same time missing the central assumptions behind the

questions they are asking. *Even with the use of typical techniques*, *we feel these practitioners are* not *"doing" Solution Focused Brief Therapy.*

And finally, with respect to one of de Shazer's "big" concerns (Hoyt, 2001), that ". . . I don't want . . . anybody to develop some sort of rigid orthodoxies. . . . That there is a right way to do this and this" (p. 30). We believe a discussion of this nature is important as a continuation of the work of Steve de Shazer and his colleagues, who started us on this road of "doing more of what works," especially when what is *supposed to work* might not be working as well as it could.

We will know our efforts in this article were successful when:

- We are clearer about the minimal descriptors of SFBT that remain consistent regardless of the language, frames of reference, or abilities of the client;
- We see that research definitions of SFBT match with what actually happens in solution focused sessions;
- We notice that SFBT is identified by its unique selling points, which appear to be the role of the therapist, the focus on co-construction of what's already working, and what we need to do more of, or do differently, to reach the client's own aims.

SOLUTION FOCUSED DEVELOPMENT

Solution Focused Brief Therapy has, since its beginning, been described as a "living process" developed by listening to feedback from clients rather than borne out of a theory or rigid beliefs (de Shazer & Berg, 1997). This differed from the development of problem-focused therapies that arose the other way around; there was a detailed definition of what was "wrong" with a person, followed by the development of a treatment that would "fix" what was wrong. These prescriptive treatments lent themselves well to being standardized because they were problem or diagnosis based rather than client based. Thus treatment protocols contained observable elements that distinguished them from other treatment procedures. It was a natural step during the development of any therapy for clinicians and researchers to develop a set of standard "key" techniques as evidence of the approach.

By contrast, the development of SFBT consisted of the therapists learning from their clients what was useful during therapy such that the client, rather than the therapist, was in charge of deciding which questions were helpful and which were not. In this sense, the therapists were learning from the clients what things worked in therapy. Additionally, therapists were learning from each individual client what a successful therapy outcome would look like for them (de Shazer, 1988), which was in contrast to more traditional approaches where the therapist knew what the client needed to achieve. Thus, SFBT came to be defined by privileging the individual's view of what works. From this work de Shazer and colleagues learned that a future-focused process that included talk about things other than the complaint was helpful. The development of SFBT in the early stages was very much a flexible 'progress in work' (de Shazer, 1985).

Major Tenets That Characterise SFBT

Information gathered about what worked in therapy needed to be grouped together to form an underpinning structure in order to establish what distinguished SFBT from other types of therapy. An operational definition of what one would see or hear during a solution-focused session was required so that the process of doing Solution Focused Brief Therapy could be adequately amended, taught, and researched.

In his last book, de Shazer and co-authors (de Shazer, Dolan, & Korman, 2007) set out the following as the major tenets that inform and characterize Solution Focused Brief Therapy (pp. 1–3):

1. If it isn't broken, don't fix it;
2. If it works, do more of it;
3. If it's not working, do something different;
4. Small steps can lead to big changes;
5. The solution is not necessarily related to the problem;
6. The language for solution development is different from the language needed to describe a problem;
7. No problems happen all the time; there are always exceptions that can be utilized;
8. The future is both created and negotiable.

Of these, the authors highlighted number 5 as the one that clearly set SFBT apart from other forms of psychotherapy available at the time.

The Key Role of the Therapist

The authors go on to say that it is the *role of the therapist* in solution-focused therapy that marks another difference from more traditional forms of psychotherapy. They are clear to say that the primary tool of the therapist is asking questions that are almost always focused on the present or the future (de Shazer et al., 2007). Secondary to asking questions is listening to replies with a constructive ear (Lipchik, 1988) and taking seriously the replies that are given.

A solution-focused therapist must have an uncompromising belief that the client is expert in what will work best for them (de Shazer et al., 2007). The job of the therapist is to ask questions and listen to the answers well enough to hear evidence of previous solutions and exceptions to the problem. It is, according to de Shazer, critical that the therapist show he is taking what the client says seriously (Hoyt, 2001). The therapist is invested with the responsibility of learning and using the client's language and frames of reference, of noticing and naming the competencies already evident in the person's situation, and in finding aspects of the client's situation on which hope for the desired changes can be reasonably built.

And lastly, the therapist is responsible for complimenting the client on doing what works even though they have experienced problems. The therapist usually suggests an experiment that is based on the co-constructed understanding of what has already worked, which the client may or may not choose to act upon after the session (de Shazer et al., 2007).

Thus, asking questions, taking the answers seriously, listening out for previous solutions and exceptions, as well as complimenting the client and suggesting an after-session experiment all appear to be key tasks for the therapist.

The key techniques of SFBT are good ways for the therapist to show that he or she is working within these key tenets, and at the same time they are not the only ways to accomplish this. If we were to see or hear evidence of the therapist upholding these key tenets, we believe we would be witnessing the "doing" of Solution Focused Brief Therapy, even if the typical techniques were not used.

Further evidence for describing SFBT without relying on the use of specific key techniques were mentioned in the previously referenced interview with Michael Hoyt (2001). In one interview, de Shazer said he preferred to think of his contribution to the theory of SFBT as a description of various pathways through which the client and therapist could, together, predictably move from complaint through to goal achievement to solutions. He went on to say in this interview that ". . . every session is somehow a unique event and that the main thing the therapist has to do is listen and keep it simple. . . . I think the clients will tell you want to do" (p. 4). This echoes de Shazer's earlier suggestion that solution-focused work involves a coherent description of a sequence of events within a specific therapeutic context (1988, pp. 62–63) and that a "solution focused interview" might best be described with a multiplicity of examples with similarities like variations on one musical theme (p. 73).

The above statements indicate to us that de Shazer and his colleagues were sensitive to the need for the therapist to fulfil their important role in a way that was compatible with what worked best for the client. We can see, even though it is not explicitly stated, how SFBT described by a "multiplicity of examples, like variations on a central theme" could make this type of therapy accessible to people, regardless of their cognitive capacity or their ability to make use of key solution-focused techniques.

The Typical Solution Focused Interventions

At the same time as gleaning the key tenets of SFBT, the clients were also teaching de Shazer and colleagues about specific interventions that seemed helpful. Early writings of the group show the development of the formula first session task (de Shazer & Molnar, 1984), overcoming-the-urge task and taking a session break (de Shazer, 1985), use of scales and the "What's better" question (de Shazer, 1986), pre-session change questions (Weiner-Davis, de Shazer, & Gingerich, 1987), finding exceptions (Molnar & de Shazer, 1987), asking coping questions (Lipchik,

1988), the miracle question, competence talk, and prediction task (de Shazer, 1988), as well as setting well-formed, small goals (de Shazer, 1991).

In later work, de Shazer & Berg (1997) noted that even though Solution Focused Brief Therapy was minimally structured and individually tailored, there were certain techniques that therapists and their clients usually used that would be recognizable as solution focused. These included:

1. The use of the miracle question at some point in the first interview;
2. Asking the client to rate something on a zero or one to ten scale at least once during the first interview and at subsequent sessions;
3. Taking a break during the interview;
4. After the break, giving the client compliments, frequently followed by an experiment to try after the session.

In the later publication (de Shazer et al., 2007), pre-session change, what's been better, and coping questions as well as solution focused goals were added to the above as specific interventions *typically* used during this type of work (pp. 5–13). In this, and much of the earlier solution-focused literature, there is little if any attention given to how to use these solution-focused techniques when the client either cannot (due to limited capacity) or does not find these questions useful.

Other researchers have developed definitions of what constitutes SFBT for the purposes of the work they have done or are continuing to do. The European Brief Therapy Association (EBTA) adopted the minimum requirements of asking and following up on the miracle question, asking and following up on a progress-scaling question, and giving compliments, all within the first session. In subsequent sessions, the requirements include asking "what is better?" and following up on responses to this, asking and following up on the progress-scaling question, and giving compliments at the end of the session. A break in the session is optional, and the definition includes directions that the therapists should focus on using client's language, finding resources, and discussing exceptions and coping skills, and should adopt a respectful, non-blaming, cooperative stance whilst working within the client's frame of reference toward client-generated goals (Beyebach, 2000).

Conoley et al. (2003) developed a checklist to ensure the work done with three individuals was indeed solution focused. They included socializing and joining (what George, Iveson, & Ratner, 1999 called "non-problem" talk), problem description, detailed goal negotiation and identification of the difference achieving the goals would make, the miracle question, exception-finding, setting small goals, scaling questions, re-stating the goal, taking a break, complimenting, and suggesting a task (pp. 373–374). We noted that therapists using this structure had more requirements than those using the EBTA structure above, suggesting differences of opinion regarding technique-oriented definitions of SFBT.

Beyebach and Herrero (2004) constructed a Treatment Integrity Form for Stuck Cases, which included the miracle question being asked and followed up on the

first session and replaced by "what's been better" questions in subsequent sessions, use of scaling and follow up questions, and giving compliments as minimum indicators of SFBT, which is consistent with the EBTA definition. Options on this form were asking about exceptions, internalizing language when highlighting exceptions, goals, or resources, making normalizing/empathic statements, re-channelling problem talk towards future solutions, and choosing from a list of possible solution-focused experiments.

Lehman, Spence and Basham (2007) constructed a solution focused fidelity instrument in the form of a self-report questionnaire from the therapist and a feedback form from the client. The therapist's instrument consists of 18 statements, organized in three overall areas (alliance building, solution talk and end-of-session feedback), which are rated on a seven point scale from "*not at all"* to "*clearly and specifically."* There is no indication of the minimum total required in order to satisfy the criteria of doing Solution Focused Brief Therapy.

Alliance building includes finding out session aims and to what extent these are related to the overall goals for therapy, asking what's been better, asking the miracle question, summarizing the client's comments, and complimenting the client. Solution talk involves asking exception, amplifying, scaling, reinforcing, and what else questions, describing next small steps, and asking what differences reaching his or her aims will make to the client. The end-of-session section includes complimenting, giving a task, asking for feedback on the helpfulness of the session, and asking how similar pervious sessions have been to the present session.

None of the above authors claim to have produced the definitive identifiers of uniquely SFBT, and we do not include them here to suggest that they were intended as such. What strikes us about these definitions is that the miracle question, scaling questions, and giving compliments are common to all the definitions and consistent with what de Shazer and Berg (1997) highlighted as being typical of solution-focused therapy. However, the fourth thing they highlighted as being typical, taking a break during the session, is an option for the EBTA definition, necessary for the Conoley et al. (2003) checklist and omitted from the other two forms, again suggesting a potential lack of clarity about what techniques constitute SFBT.

We find that the extent to which the above techniques operationalize the unique role of the therapist as discussed by de Shazer et al. (2007) is variable and not explicitly clear. For example, the role of the therapist is to ask questions, use the client's language, use the client's own frame of reference, construct a common understanding of the aims of the therapy work, and listen with a constructive ear for evidence of coping skills, strengths, exceptions, and resources that might help in meeting the client's aims. Given that these are central aspects of SFBT, we wondered about having the EBTA research definition turned around, so that therapists were required to show evidence of doing these things, and may or may not use the miracle question, scaling, or compliments to fulfil their solution-focused role.

Unless one can see how a solution focused therapist fulfills his or her unique role of privileging the client's words and aims, we may not able to recognize how solution-focused work can be achieved through *various pathways* (Hoyt, 2001), and we leave open the possibility that clients who are unable to answer the miracle question or who do not understand the abstract relationship of "more than/less than" well enough to find scaling helpful (Bliss, 2005; Bliss & Edmonds, 2008) will be seen as unable to benefit from SFBT. We are concerned that this then can lead to claims that solution-focused therapy will not work, or is ineffective, in instances where techniques were used without an understanding of the underpinning beliefs.

Furthermore, we have found little research on the extent or consistency with which the typical techniques are used. Gingerich and Eisengart (2000) provided an indication of which SFBT techniques were used by various therapists, and found that goal setting was the most commonly used technique, compliments and giving a task were next most frequently used, with exceptions, scaling questions and the miracle question being even less widely used (see Collcott, 2007 for a fuller discussion on the occasional use of the miracle question). These findings suggest that what solution-focused therapists really do in a session may not be closely related to technique-oriented definitions of the approach. We are not sure, then, that research outcomes match what happens in clinical therapy sessions.

Perhaps not surprisingly, we have found no literature that directly assesses the extent to which SFBT workers adhere to the underpinning beliefs of the approach, or individually tailor the approach during sessions, possibly because adherence to these aspects of solution-focused therapy are difficult to quantify and observe.

CLINICAL EXAMPLES OF SFBT WITHOUT USE OF KEY TECHNIQUES

It is our clinical experience of listening to and learning from people who have limited cognitive abilities due to stroke, disease, developmental delay,[1] or autism that has led us to question the technique–oriented definition of SFBT. We have found that co-construction of a preferred future and the identification of ways in which parts of that preferred future are already happening, as well as the identification of next steps toward success, can be done in therapy without necessarily using the text of the miracle question, or zero to ten scales, or taking a session break, and sometimes without asking "what's been better" questions, or giving between-session tasks.

[1]The term "developmentally delayed" is the accepted term in America to categorize individuals based on their tested intelligence (IQ below 70). Central to the definition is an impairment of learning ability and adaptive or social skills that began before adulthood. Other terms for the same population which appear in some references include "learning disabled," "developmentally disabled" or "mentally handicapped."

When using the approach with people who have developmental delay, the first author has noticed clients taking extra time to get used to having their competencies highlighted and taking extra time to practice noticing when they are coping well with situations. It must be said that this is sometimes also true for people without developmental delay. Some people find it so foreign to hear positive things said about themselves, and to find a therapist who is genuinely interested in their opinions, that we can move no further than doing only these things during the first one or two sessions. We consider these sessions to be in keeping with the key tenets of SFBT, even though an observer would not hear us use the miracle question or use scales within the first session.

Additionally, many people with whom we work do not have the cognitive capacity to imagine a future that is different from the present or the neurological capacity to generate new ideas. We have noticed that the use of the standard miracle question with such a person is unhelpful and, at the same time, one may dig for a preferred future by asking questions using the client's own words, frames of reference, and by doing whatever works to help that person say what they would like to be different after a session. We might cut pictures out of magazines to make a collage of a preferred future. We might make multiple choice options from which the person can choose or not choose something. We have constructed models from individual sticks on which competencies were written before they were added to the model. Together with the client we have then "tried out new sticks to see which areas of the model (therefore which competencies) we want to expand upon. We have worked alongside a client in the garden in order to observe first hand some of the competencies and skills of the client that she could not tell us in answer to a direct question. Wonderfully, these creative ways of learning about the person were co-constructed via tenacious solution-focused questioning and listening between us all. In another example, from the first author's work (Bliss, 2005) with a person of limited language skill, the first session was spent with the author matching the client's language such that they both took turns saying "I don't know you" for the first few minutes of the session. The client's anxiety upon first meeting the therapist was so high that it was impossible to ask the miracle question or use scales, even though it was quite possible to match the client's language and try to learn about what was important to her (pp. 22–23).

There have also been times in our work or in the work of our colleagues when first sessions have not included moments when the miracle question or scaling questions could be asked within the flow of the conversations. Indeed the first author can recall one situation where the mother of a young man with autism described her 21 years of difficulties for the first three therapeutic sessions. This was her unique way of cooperating with therapy (de Shazer, 1984), and whilst it was possible for the author to try reframing her story using the language of strength and hope, it would have been very disrespectful to have attempted a miracle ques-

tion in the first session or to ask her to locate herself on any zero to ten scale. She clearly said to the author that talking about her history of problems was helpful during each of the first three sessions.

In the above situations there were solution-focused conversations going on, but miracle questions and scales did not have a useful purpose.

It is important to note that one might consider an instance of the therapist creating in-session opportunities to see competencies first hand as "a solution-focused intervention" so we are not at all suggesting that SFBT ought to be seen as "intervention-free." Our confusion comes because we are not using the typical techniques within the recommended time frame and thus appear not to be doing SFBT at all.

In common with the authors, Smith (2005) noted that when using SFBT with people who have developmental delay, a structured approach with the use of certain techniques at set times has been unnecessary and often confusing for the client. Rather, he found that most clients who find SFBT helpful do so primarily because of the use of a single technique that makes sense to them, and the specific technique that works varies from individual to individual.

THE SMALLEST SOLUTION FOCUSED PARTICLES

In the spirit of minimalist tradition, we looked about for the smallest possible number of parameters that distinguish solution-focused work from other kinds of therapy. With such a minimalist definition, it would be possible to observe how the therapist uses the client's language and frames of reference to co-construct the client's preferred future, discover the parts of that future that are already happening, and construct signs that both are moving in the right direction, without restricting the clients or therapists to the use of certain solution-focused language, timelines, or techniques. The therapist's unique role of learning about and doing whatever works with the client is the essence of what makes SFBT unique in the therapy world. It is these unique aspects which need to be operationalized in the most minimal, least restrictive way.

The Role of the Client

Obviously a minimum requirement for Solution Focused Brief Therapy is that it takes ". . . at least two people to construct a [social] reality" (Hoyt, 2001, p. 25). Even though the role of the therapist has been highlighted as one of the unique things about SFBT, we wished for a moment to consider whether or not anything the client does or does not do during a session might help us define whether that session was or was not solution focused. In considering the role of the client, we reached a mildly surprising conclusion. The clients actually have *fewer*

requirements put upon them when coming for SFBT than they do with other types of psychotherapy.

Clients, for their part, need to turn up for the appointment and have some means and motivation of communicating their aims, as well as discovering the next steps with the therapist. They do not have to accept or agree with any diagnosis or even believe they have a problem. If they do have a problem, they do not have to talk about it. They do not have to learn or adapt to the language of the therapist or to understand a theoretical framework for their problem. They do not have to comply with therapist-ordered treatment or do tasks or assignments that make no sense to them. They do not have to "fit in" with the therapist's frame of reference or theory of change. Some people are turned away from traditional kinds of therapy because they do not "take responsibility" for their role in the problem, but this would not happen in Solution Focused Brief Therapy.

This is very good news indeed for people who have not had success with more traditional therapy experiences. If all we need for successful therapy is a client who is willing to answer questions and keep doing what's already working, then it will be difficult to find a client who is "non-compliant" or "resistant," as can be done in other therapeutic approaches. In fact, these concepts do not exist within solution-focused work (de Shazer, 1984).

Solution Focused Therapist Behavior

It becomes clear that defining therapy as solution focused is based entirely on the behavior of the therapist. It has been our experience that most therapists of various therapeutic persuasions sign up for working jointly with clients, working towards client-centred goals, identifying strengths and resources that the client already has, and talking about times when the problem isn't so much in evidence. Many also use scaling as a means of identifying the severity of symptoms and gauging progress in therapy. Taking this at face value, many techniques considered indicative of SFBT appear very much like techniques of non-solution focused therapy.

We think the *absolute minimum requirement* for uniquely solution focused work is the co-construction aspect which requires that the *therapist learn from the client.* Thomas and Nelson (2007) put this very clearly when they establish a solution-focused posture of curiosity, respect and being tentative. We believe, based on our own clinical experience and such literature as we've been able to digest, that the smallest particles or indicators of SFBT involve the therapist, with language that shows evidence of curiosity (i.e., using mainly questions) and respect (i.e., showing evidence of listening to, believing, and using the answers clients give) that yields to a joint understanding (i.e., one that the therapist keeps checking with the client) of the client's frames of reference and what they mean. An observer would hear present and future-focused questions being asked, hear the therapist use the same language as the client in order to ask clarifying ques-

tions, and hear the therapist restate their understanding of what they have learned from the client about:

a) The person's preferred future and implications thereof (perhaps using the miracle question, but perhaps not);
b) How they both will know when they are moving in the right direction (perhaps using scaling questions but perhaps not);
c) What the client can do more of or what he or she might do differently to start moving in that direction;
d) How they will both know when they have done enough SFBT.

We would not suggest a time frame for this work and instead would look for evidence that the work took as long as it needed and not a moment more.

We think these four points are what makes our work with clients who have cognitive or neurological differences uniquely solution focused. An observer may not see exceptions to the problem being pursued within a set time frame. We may not ever suggest a task or take a break before the end of therapy. Yet we believe we, and others like us who pick and choose among specific techniques based on what works for the client, are still doing Solution Focused Brief Therapy.

Further, we think that this way of defining solution-focused therapy is consistent with what de Shazer meant when he viewed his contribution to the theory of SFBT as the description of various pathways through which the therapist and client could, together, move predictably from complaint to solutions (Hoyt, 2001).

CONCLUSION

We have tried to trace how SFBT moved from being highly individualized to being technique oriented and have found it to be a confusing trail, with the original developers of SFBT saying that it ought to be driven by what is useful to the client and at the same time that certain techniques ought to be used within certain timelines. We have put forward our idea that therapy can be identified as solution focused if there is evidence that the therapist is learning from the client and that the two are co-constructing a way forward using the client's language and the client's own aims. We would not necessarily hold to the ideas of previous authors that certain techniques, such as the miracle question, session breaks, scaling questions, etc., need to be used in order to qualify the work as solution focused. These may indeed be the first tools out of the box, if the client finds them clinically useful, and at the same time we feel they are not adequate in and of themselves to be used as defining measures of the solution focused-ness of the therapy.

We suggest the next steps might be to assess various sessions, both of SFBT and of other types of therapy, to see what evidence there might be for or against our minimalist requirements for the "doing" of Solution Focused Brief Therapy.

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