

Inbetween – neither inside nor outside: The radical simplicity of Solution-Focused Brief Therapy

Mark McKergow¹ PH.D.

The Centre for Solutions Focus at Work, UK

Harry Korman² M.D.

SIKT, Sweden

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In this paper we attempt to set out some crucial ways in which we see the practice of solution-focused brief therapy (SFBT) as differing from other forms of therapy, both in what solution focused brief therapists do and what they do not normally do at all. These differences are more radical than is commonly supposed. Chief amongst the differences are the ways in which solution focused therapists act in therapy as if humans are neither driven from the inside by some kind of mentalistic (or even molecular) framework, nor from the outside by systems or social forces. Rather our futures emerge through dialogue in unpredictable ways which do not reflect a mechanistic account. We propose that these distinctive features may have arisen because of the ways in which Steve de Shazer, a key developer of SFBT, was introduced to therapy. The increasing evidence-base for the effectiveness of SFBT calls into question the taken-for-granted foundational ideas of many therapeutic and scientific traditions.

¹ The Centre for Solutions Focus at Work (sfwork), 26 Christchurch Road, Cheltenham GL50 2PL, UK,

² SIKT, Bergsgatan 20, 214 22 Malmö, Sweden,

Address correspondence to Mark McKergow, email mark@sfwork.com

Introduction

Solution focused brief therapy (SFBT) in the tradition of Steve de Shazer and Insoo Kim Berg (see for example de Shazer 1985, 1988, 1991, 1994, Berg and DeJong 1998, de Shazer et al 2007) is a distinctive field, different from most – if not all – other therapy forms. It is characterized by what solution focused therapists do and the ideas they use, but perhaps even more by the ideas they do **not** use and what it is that they do **not** do. This paper seeks to show our view of this as clearly as possible, and in so doing to emphasize the radically simple nature of SFBT practice.

In the spirit of Ockham's Razor, always an inspiration to brief therapists, our understanding and therefore description seeks to be radically simple and we hope it to be one that helps practice by cutting off what we regard as unnecessary, and perhaps detrimental, elements. Making therapy more complicated than it needs to be is no sure way of increasing its effectiveness and perhaps one that decreases it.

Much of the existing literature on SFBT has, understandably, focused on descriptions of what solution-focused therapists do, on the techniques they use and on the assumptions they have about people in therapy. This has resulted in some other professionals (for example Stalker et al, 1999) describing SFBT as naïve and superficial. When solution focused techniques are extracted from the whole structure of solution focused theory³ and practice and interpreted within traditional psychotherapeutic frameworks, the solution focused ideas and techniques become absurd, naïve and even plain stupid.

We and most other solution focused practitioners, have not seen the need to correct or challenge these misunderstandings – maybe because we are more interested (naturally) in talking about what we do rather than what we don't do. We have also been aware of the difficulty entailed in questioning traditional psychotherapeutic thinking – which happens when we say we do not use it – because many of its premises are so deeply ingrained in our western language and culture.

Some reviewers have commented that taking a hard line here may be counter-productive. We are aware of this possibility, and at the same time wish to 'do something different' in the face of continuing misunderstandings from fellow professionals. Our view of SFBT is that solution focused therapists do not use nor draw upon most of psychological theory that is taken for granted by other therapeutic traditions.

³ The word theory is used here in the restricted sense suggested by Steve de Shazer (de Shazer 1994) as a description of what is going on in the therapy-room – in the therapy-system. Not prescription (the way it should be done) and not explanation (why it's done that way).

The collected research on the effectiveness of SFBT is impressive (see Macdonald, 2007) In October 2008 there were eighty relevant studies: 2 meta-analyses; 8 randomised controlled trials showing benefit from solution-focused brief therapy with 5 showing benefit over existing methods. Of 25 comparison studies, 18 favor SFBT. Effectiveness data are available from more than 2800 cases with a success rate exceeding 60%; requiring an average of 3 - 5 sessions of therapy time.

Therefore, this paper serves a number of purposes:

To suggest that SFBT is not only different, it is radically different.

To present the distinctive characteristics of SFBT in terms of what practitioners do and what practitioners do not normally do at all

To highlight in particular the way in which SFBT works without postulating either internal or external mechanisms in need of change

To present SFBT as a process of emerging dialogue 'inbetween' practitioner and client(s) – and no more

To suggest a historical background for these differences.

To suggest that SFBT, being radically different and demonstrably effective (at least as effective as anything else), calls into question the usefulness of much conventional psychotherapeutic wisdom

What's distinctive about SFBT?

First, let us examine what we, the authors, consider to be the essentials of SFBT. To the casual observer, solution focused conversations are sometimes mistakenly seen as ordinary conversations, since they appear to be just talking about ordinary daily activities of life. The solution focused therapist listens actively for what the client wants (in the past, present and future), points to it by echoing, paraphrasing and summarizing, and asks questions to create detailed descriptions of cognition, emotion, behavior and interaction when the ordinary daily activities in the client's preferred future are happening. Such questions include:

- What are your best hopes from our work together?
- How will you or your best friend know that having been here was useful for you?
- What would be/will be the first tiny signs that things are better?
- Suppose a miracle happened while you slept and the problem that brought that you here was gone – just like that – but this happened while you slept so you don't know it

happened. How would you discover after you woke up that the miracle happened? How would your family and friends notice? How would you notice on them that they noticed?

- Where are you now on a scale from 1-10, where 10 is that your best hopes for our work are realized (or where 10 stands for the day after miracle)?
- How come you're that high? What else?
- Who would be the first person to notice that things had improved for you? What would they notice? What else? What will you notice in that person when he or she notices that things are better for you?
- What is already better since you decided to seek help?

The presuppositions of these questions are few and simple:

- The client wants something to be different as a result of seeing us (and can know what it is).
- Things can get better.
- The client is capable of setting his/her own goals and is capable of evaluating progress towards that goal.
- Change in the direction of better is recognizable.
- Other people will notice when things improve.

The solution focused therapist makes deliberate choices about what parts of the client's utterances will be commented upon or highlighted and which parts will be only acknowledged without getting into further detail. The therapeutic conversation is thus developed one turn at a time. For example:

Client: (Comes into the room, sits down, sighs deeply and says) *"I want to be a better mother but I'm such a worthless, worthless, worthless person."*

SF therapist: *"Oh – how terrible!..(pause)...But you want to be a better mother?" (gently acknowledging how terrible it is to feel worthless, and picking up the stated desire to be a better mother – something the client says she wants)*

Client: *Yes!*

SF therapist: *“So – suppose you were successful with that – becoming a better mother – how would your children notice that you became a better parent?”*

The therapist chooses to build the conversation on the part of the client’s utterance that has to do with what she wants (wanting to be a better mother) – and to only acknowledge the part she doesn’t want (feeling like a worthless person). It is important to note here that, although many forms of therapy may have elements like this, in SFBT there is little else. The solution focused therapist does not interpret the client’s words or behavior in relation to any pre-existing theory; for example speculating or investigating about why she says she feels like such a worthless person.

Building on this, it is possible to draw up a table of what solution focused therapists do and compare it to what they don’t normally do at all. The phrase ‘what they don’t normally do at all’ is very carefully chosen. SFBT can be viewed as a search to find how people want to live their life and how to make that happen in each case. It sometimes happens that what we do does not yield enough results and we may then start doing what we don’t normally do at all. This is a point where there is some disagreement among solution focused practitioners, and indeed between the authors. It is argued by one author (MMcK) that doing what we don’t normally do at all *is* part of SFBT, in the situations where skilful and gently persistent application of the normal model has not produced useful results. The other author (HK) sees that as trying other therapeutic models. Whatever, the broad thrust of the approach is clear.

What solution focused therapists do	What solution focused therapists don’t normally do at all
Focus on what the client (and others involved) say they want, and what difference that would make during ordinary daily activities.	Focus on what’s wrong and why
Ask about what helps the client progress in the direction he/she/they want	Ask what stops or blocks the client
Use the client’s descriptions of what they want and what of this is already happening to help everyone involved decide what is most useful for the client to do more of. In other words we “diagnose” what we and the client agree on that is going right.	Diagnose pathology or use theories to understand what is going wrong in client’s lives
Listen very carefully to what clients say, believing that in the words themselves there lies everything necessary for clients to find and build solutions. Solution	Assume that what is left unsaid or what is deemed to be underneath or behind the words is more interesting or

focused therapists following de Shazer's lead (de Shazer 1994) talk about this as "staying on the surface".	significant than what is said
Use simple concrete language to build on the client's descriptions	Introduce abstract, mentalistic or systemic language into the conversation or into their thinking at any stage

This is a radically simple view of SFBT. However, it seems to us to encompass what we, the authors, do – or at least strive to do - in our own practice. This practical view picks up on the theme within the brief therapy movement of Ockham's Razor – that nothing inessential should be assumed, and that therapy should be as brief and simple as possible.

The really extraordinary thing is that following the left hand column is at least as effective as any other treatment (Macdonald, 2007). We therefore propose that it is time to broadly reconsider what is necessary to do effective therapy.

SFBT can be viewed as a form of practice which helps clients simplify their lives. It does this by simplifying how therapists and clients talk together about life and by helping the clients focus on and attend to what they say is important and helpful to them. We like to think that this is how Wittgenstein (1958) hoped to use language; to 'show the fly the way out of the fly-bottle' in dissolving the problems of philosophers and helping them get out of confusions created by language. The solution focused dialogue is a highly practical pursuit and has different priorities to neighboring fields which may see academic categorization, description and explanation as being important precursors to the work of change.

None of the questions we ask depends on the assumption that the client is hindered or troubled by some internal 'mechanism' – some hidden behavioral or mental process in the words of Harré (1995) - which we or they need to change. Nor are they at the mercy of some external system. It is, we propose, an unnecessary complication for the therapist to introduce either of these concepts into the conversation, or into his or her thinking. Furthermore, we think that introducing these concepts into the thinking and/or the conversation hinders us from doing solution focused therapy.

No internal mechanism needs to be found and changed

One conventional psychotherapy wisdom holds that an individual's behavior and interactions with others (particularly behaviors and interactions that are labeled as being pathological) are driven by internal mechanisms hidden from view, and that in order to change behavior the internal mechanisms must be changed. This is like adjusting a machine or some kind of computer program – as if people were at the mercy of bugs in their operating systems. There are two forms of mechanisms to consider – mentalistic and molecular.

Typical mentalistic mechanisms include:

- Beliefs
- Personality Traits
- Attitudes
- Motivations
- Values
- Thoughts
- Emotions
- Psyches
- Mental Maps
- Weaknesses
- Strengths
-

SFBT practice does not follow this conventional wisdom. Solution focused therapists do not make assumptions about any of the above and they do not try to change them. People in solution focused therapy can and do change their lives and leave all manner of problems, diagnoses and other ailments behind them without any use of, reference to or mapping of these internal 'things'. Indeed, even problems declared by clients in such terms can be handled quite satisfactorily by using and building everyday descriptions of their lives.

In the category of molecular mechanisms we might include brains and (perhaps) genes. Solution focused therapists (like most other therapists) do not discuss these with their clients. The latest neuroscientific results may be interesting in helping us understand more about the potential of people or about their limitations and perhaps understand more about what goes on during therapy, but such findings are many steps removed from everyday therapeutic practice.

Of course, activity in our brains is associated with our behavior and of course the genes a person possesses limit the range of possible behaviors and interactions of that person. Genes do not control the behaviors and interactions that are used in a particular situation – rather, they set 'parameters of possibility' and allow huge variation to emerge. Stephen Rose has written widely against genetic determinism (see for example Rose, 2005) and in terms very compatible with this position. Wittgenstein and those inspired by his ideas show from another perspective the nonsense of imagining that we are controlled by our brains (see for example Bennett and Hacker, 2003).

It is worth noting that this position has, in fact, been argued for in a theoretical way for some time, for example in the literature of sociologically-oriented social psychology. The proponents of 'discursive psychology' notably Rom Harré (Harré 2000, Harré and Gillet 1994) and the Loughborough group led by Professor Jonathan Potter (Potter and Wetherall 1987, Potter 1996) have been coming to very similar conclusions albeit from a more academic and less practice-focused perspective. McGee et al (2005) have noted that there is a range of positions implied in discursive psychology and social construction from moderate (discourse constructs accounts of the social world around us) to extreme (there is no reality and all accounts are equally valuable). We, like them, position ourselves at the moderate end of the spectrum.

All this does not mean that solution focused therapists say that “brains” or “genes” do not exist or that such things as “attitudes” or “motivation” can’t be mapped, discussed or examined. Indeed, we often talk with clients about their strengths, useful personal qualities and so on⁴. However, to think of these as mechanisms which must be changed in order for any other changes to occur is not only misleading, it leads us immediately into doing something in therapy that is not solution focus. This sets SFBT apart from other models.

We realize that mentalistic vocabulary is normal in the domain of psychology and psychotherapy. However, these concepts are not necessary to promote change. And if they are not necessary we might question their usefulness, at least to change-focused practice.

No external mechanism needs to be found or changed

Another conventional wisdom holds that individuals are part of systemic processes in action which, if changed, will result in change for the individual. This view sees people as being at the mercy of external macro-level forces, including

- Systems
- Family structures
- Power structures
- Narratives
- Cultural norms
- Karma
- ...

Such ideas also form no necessary part in SFBT practice. This is not to say that, for example, cultural norms have no influence. Neither is it to say that taking a everyday conversation cannot be viewed through a systemic perspective. However, this is not the same as acting as if there were an overarching ‘real system’ or ‘power structure’ that must be found, mapped, followed or changed, or else the work will be in vain. Rather like the mentalistic vocabulary of cognitive or psychodynamic psychology, the systemic vocabulary is not necessary to promote change.

The idea of second order change has also been left behind by SFBT practitioners. This was a key element of the preceding Mental Research Institute model of brief therapy (Watzlawick et al 1974). Work published by the team at Brief Family Therapy Centre during the development of what was to become SFBT shows clearly that this idea had been abandoned by 1986 (Nunally et al 1986). This paper also makes clear that frameworks based on continuous/discontinuous

⁴ Readers may be wondering about the position of compliments – offering views of the client’s strengths, qualities and so on – in SFBT practice. It is quite true that we as solution focused practitioners offer such compliments, so that strengths may enter the conversation. In our view these strengths are used conversationally, to give an alternative view of the client and their situation, rather than as fixed elements which must somehow be worked on, worked around or taken into account.

change (Dell and Goolishian, 1979), homeostasis and morphogenesis (Maruyama, 1963), and catastrophe theory (Thom, 1975) were also tried and passed over. Each of these, while seeming like an attractive option, was found by the BFTC team not to reflect cases as they appeared. Nunelly et al also cast the ideas of resistance and paradox as 'red herrings'.

We wish to distinguish between macro-level systems such as those listed above and micro-level interactions – the everyday turn-by-turn self-organizing of conversation, response and going on (in the terms of Wittgenstein) using language together. The ways in which norms, narratives and power are locally constructed and (therefore) locally changeable are of great interest to us. We are very aware of the way in which small interactions and dialogue can create ideas of macro-level phenomena. However, the very fact that these are created by micro-level interactions means, to us, that they are changeable by the same kind of micro interactions.

As an example we might look at an old-fashioned organization where women are treated as second-class employees. One could say that such an organization exhibited a macro-level 'sexist culture'. It might be tempting to start to think that this culture somehow caused the unacceptable behaviour, and that changing the culture would therefore improve matters. We would say that this is a confusion – the culture does not 'cause' the micro-level behaviour, it IS the micro-level behaviour and the associated language and responses.

Among systemic factors that we don't address, unless brought into the conversation by the client, are questions of social justice. This doesn't mean that we don't see this and similar questions as being important. It's obvious and clear for everyone involved in therapy that the options are different for someone who is white upper middle class compared to someone who is an illegal immigrant with similar presenting problems. The possibilities are different and it would be naïve not to be aware of it - which is not at all the same as insisting that the bigger issue must be addressed before working with the individual case. On the contrary, progressing the individual case is one way of tackling the wider context.

Inbetween: the emerging world of dialogue and interaction

So, solution focused therapists don't use ideas from cognitive psychology and do not act as some kind of inner or outer mechanism needs to be fixed. How could we describe what IS done in general terms?

Solution focused therapists get along doing the things that people do – talking, conversing, reflecting, sleeping, joking, wondering, interacting through language and behavior at close quarters. The act of *responding* – to another person, to a question, to an event, to a setback – is not seen as one controlled by inside or outside. What happens at any moment is not seen as scripted, controlled or determined by any of these - it is a moment of creativity within the context of all that has gone before and all that may become. This means that SFBT is not amenable to reduction to a manualised treatment in the normal sense; what happens next depends on what just happened, not on a pre-determined schema.

The way in which conversations self-organize, how dialogue emerges, is also being studied by those from other fields including discursive psychology (as mentioned above), complexity theory (see for example Cilliers 1998, Stacey 2005) and microanalysis of dialogue (McGee et al 2005, Beavin-Bavelas, de Jong & Korman 2008). In the best sense of the words, we make it up as we go along. This form of practice is connected to ethnomethodology pioneer Harold Garfinkel's (1967) idea of 'ad hocing': the methods people use to sustain conversations and a shared sense of social meaning, order, and reality.

These ideas have been present since before SFBT got started – the Interactional View (see for example Watzlawick and Weakland 1977) was the key basis of the Mental Research Institute group in Palo Alto, through which Steve de Shazer and Insoo Kim Berg first met. In our view the Interactional View is a key element which has more wide-ranging implications than many have realized.

The tiniest details of life, deliberate or accidental, produce a rich and surprising unfolding future. It is in this unfolding that people act as clients in ordinary daily activity and as therapists in conversation with our clients, co-constructing possible preferred futures. (Solution focused therapists hold their focus on the 'here and now' as one way to prevent their attention from wandering into theory-land where they would be tempted to construct explanations for what is going on rather than listening carefully to the client's descriptions.) It is in this sense we use the word Inbetween – in order for there to be interactions and unfolding there must be something with which to interact. It may be that this process is so everyday that it is hard for some to take it seriously as a medium of change – rather as if there were an idea that the air we breathe must have some secret hidden ingredient to sustain life as well as the boring oxygen, nitrogen and so on.

This position of Inbetween is difficult to describe in conventional language. To think and speak of internal mechanisms like "personality", "motivation" etc gives these "things" an existence which they don't really have. External mechanisms like systems and narratives seem to deny the influence of the individual. The middle way, following Wittgenstein, has us being cautious about reifying mentalistic properties without denying that it might, in some circumstances, make sense to talk about them. However, those circumstances are not normally to be found in SFBT practice.

Why is SFBT different?

In 2002 Steve de Shazer was doing a workshop in Malmö, Sweden and someone in the audience asked him how he became a therapist. He answered that he never saw himself as a therapist and told the following story:

"I was not interested in psychotherapy and I had never read anything about it. I was a researcher in sociology with an interest in how language works. One day in the late 60's on the

look-out for an interesting research project I was waiting for someone in a library, and while waiting I picked a book at random from a shelf. It happened to be a book about Milton Erickson by Jay Haley. On the page that I opened, Haley stated that Erickson's sessions and strange homework tasks followed no rules. My immediate reaction was that this is nonsense. Language and communication is rule-bound and people wouldn't be able to communicate if there were no rules.

Haley writes well and the book made an interesting read and Erickson's work made a lot of sense, so I read some more and eventually I read everything that I could find written about Erickson and all I could find that Erickson had written himself. I also read some of the other books on the same shelf about psychology. These other books I found speculative, badly written, full of superstition and uninteresting.

So I started this research project. Trying to figure out how Erickson constructed his interventions. What were the rules? A lot of Erickson's cases were published – actually I think that there are more cases of Erickson published than of any other therapist. So I started organizing the cases looking for similarities and differences and patterns and trying to describe the rules that I knew Erickson had to be following. I found 4 rules and divided up the cases between them – putting them in piles: one pile for each rule and one for the cases where I had not yet found a rule. This last one I called the “weird cases” pile.

When I had put all the cases in the piles I discovered that the “weird cases” pile contained about 50% of the cases. This bothered me and I speculated that this was so because there must be crucial information lacking in the descriptions of the cases and without that information it would be impossible to create the rules that could explain those cases. So – since I had now read most of the literature by and on Erickson and had developed what I felt was a clear sense of what Erickson was doing and thought it made perfect sense – I decided I had to start seeing cases myself to create descriptions so that I would be able to figure out the rules.

So I set up this clinic in the sociology department and started seeing cases and soon found that about 50% of the cases I saw fitted into one of the 4 rules and about 50% of the cases went into the “weird cases” pile. Since the proportions were the same as Milton Erickson's, I was confident that I was replicating what Erickson was doing. Well - I was wrong. When I saw a filmed session with Milton Erickson 15 years later my immediate reaction to his work was: “Gee – he's doing it all wrong!!!”

So Steve de Shazer learnt something he believed was Ericksonian therapy through books and he was wrong. He invented something very different. The foundation of Solution Focused Brief Therapy is a huge misunderstanding of Milton Erickson by a sociologist interested in how language works. We propose that this is probably the most important reason why the activities of solution focused therapists are so distinctly different from what other therapists do. It may also connect with de Shazer's fondness for the idea of 'useful misunderstanding' (see for example de Shazer (1994).

Why not use the best of SFBT with the best of other models?

Using SFBT questions and concepts within other frameworks leads to the approach becoming naïve and superficial. For example, in the Norwegian feature film *Kunsten å tenke negativt* (The art of thinking negatively, 2006) the film starts with a series of scenes depicting a very traditional view of a very depressed man in a wheelchair contemplating suicide and his worried girlfriend. Subsequently the girlfriend calls in the ‘solution focused therapist’ and the ‘positivity group’.

Everything the therapist and her group does to be helpful is related to the traditional view of the “depressed man in his wheelchair and his worried girlfriend”. There are no scenes depicting “exceptions”, for instance when the man in the wheelchair laughs at something or the girlfriend finds pleasure in his company. There are no scenes showing anything about what the young man wants or anything about desires or hope. Solution focused work only makes sense when things like these are brought to the foreground but in this film there are none. The “optimistic” attitude is convincingly shown to be not only ridiculously naïve and superficial but also based on ‘denial’⁵. The film’s conclusion is that for ‘real’ change to happen one has to work through one’s problems seriously – thus the title of the film. The film is a good example of what happens when you use SFBT eclectically. Some solution focused techniques are applied within a traditional psychotherapeutic framework and this creates an image of the solution focused therapist and the SFBT model as being not only ridiculously naïve and stupid, but perhaps even dangerous since it doesn’t deal with problems in a serious way.

Other forms of practice include elements which, at first glance, look like SFBT. For example, MacKinnon et al (2006) advises psychodynamic interviewers to avoid questions involving the word ‘why’, to ask about exceptions as well as details, and ask about positive aspects of clients’ lives. Asen et al (2004) explicitly include solution focused and narrative questions in teaching doctors how to assess patients’ family systems. However, their reasons for doing this are very different from those given by solution focused therapists for doing similar things.

Steve de Shazer preferred to completely ignore traditional ideas which led to some bizarre misunderstandings. When someone asked Steve in a workshop “How do you work with depression (or anorexia or any other diagnostic label built on pathology)?” Steve would often answer: “I don’t understand that question!” From a solution focused perspective his answer makes perfect sense. Solution focused therapists don’t work with depression; they don’t solve problems or work with them at all. They do solution building with people in the same way whatever their diagnosis⁶ – as outlined above and well described in many books and papers. The

⁵ “Denial” as a defence mechanism is a concept invented by Sigmund Freud and elaborated by his daughter Anna (Freud 1937). It has now entered into the realm of “general knowledge” about how things are – much like the sun rises in the east.

⁶ We might wonder, in passing, about the apparent need for SF therapists to produce books about working with specific diagnostic categories such as problem drinkers (Miller and Berg 1992). It’s possible to conclude that such books have their place in attempting to bridge the gap with other professionals who are used to working with such categories, being a place where relevant war-stories and case examples

solution building process can be similar for someone with a diagnosis of hysteria and for someone with a diagnosis of major depression. Non- solution focused practitioners seem to grapple with this, possibly because the key distinction between solving problems and building solutions doesn't make any sense to them.

As another example we can examine the case presented by one of the authors (Korman, 1997). An 11-year old girl was interviewed after having spent a fortnight in hospital because of an inability to walk. In previous interviews and examinations with a number of different pediatricians and neurologists she displayed 'la belle indifference' (smiling when she said she could not walk, etc). Because of a strong suspicion of 'hysterical palsy' she was referred to child psychiatry. During a solution focused interview centered on the miracle question she did not show any signs of 'la belle indifference' and about 25 minutes into the session she got out of bed and started walking.

In the paper Korman argues that the diagnostic sign of 'la belle indifference' is not a characteristic of the person but is a relational phenomenon and dependant on what is talked about and how it is talked about it. 'La belle indifference' depicts a special relationship between the client, the problem and the doctor/therapist – basically that the client is showing courage, is heroically supporting the hardship and expressing hope that someone else will be able to do something about the problem.

This is not the way the client behaves when interviewed in a solution focused interview. Her relationship with the doctor/therapist is very different. In that interview, where the problem of not walking is only background to what she wants to do and feel and interact in ordinary daily activities, she behaves as if she is motivated and strong-willed and successfully starts walking after 25 minutes.

These descriptions of the girl (strong-willed and motivated or beautifully indifferent) and the relationship connected to these descriptions cannot exist simultaneously. This shows the impossibility of doing problem-solving/diagnostic interviewing and solution focused interviewing at the same time. The difference in relationship brought about by the different orientations is fundamental. To put it another way, one cannot do solution focused therapy work with "la belle indifference".

Ockham's Razor cuts again

may be collected, and being a way for the SF-therapist to learn the grammar of a particular specialism – the technical terms, norms, expectations, support offerings and community around a particular field. Miller (2003) has written about this tension.

Scientists in general take the principle of Ockham's Razor seriously. When a theory, axiom or hypothesis has been shown not to be essential – to be dispensable – it can be safely put aside. The sun does not rotate around the earth (although Galileo was imprisoned for saying so). Focal sepsis (treating depression by pulling out all the sufferer's teeth – common practice in the 1920s) has been abandoned as has treating hysteria with hysterectomy. Perhaps because we, the authors, come from science and medicine ourselves, we are both keen to persist in wielding the razor and making progress by doing less.

The landmark study of Wampold (2001) has clearly shown that therapy is effective overall, and that the things which make it effective are not connected to the particular model of therapy chosen. More important are the therapeutic alliance as seen by the client, allegiance of the therapist to their model of choice, placebo effects and general therapist competence.

Some have chosen to interpret these findings along the lines of 'the therapeutic model doesn't matter'. We demur. We propose that models featuring complicated explanatory mechanisms and psychological explanations may require excessive efforts in terms of both therapist training and practice. However, the extent to which the SFBT approach leaves aside many psychological explanations and assumptions is remarkable.

With the ever-increasing number of research studies showing the effectiveness of SFBT, we can begin to be more assertive in extending our conclusions. The collected research shows that SFBT is at least as effective as any other form of practice – most of which make explicit use of either internal mechanisms ('beliefs, thoughts or whatever must be changed') or external mechanisms ('systems or whatever must be changed'). However, if neither of these shows an advantage in practice, if they only make therapy more complicated and longer, is it not time the world started to reconsider these concepts? We argue that SFBT offers a distinctive and efficient paradigm for working with people, which brings into question much that is taken for granted in the world of cognitive psychology, positive psychology and many other fields including systemic practice.

Conclusion

As SF practitioners we continue to seek to do more with less – and perhaps show how other fields could be simplified and perhaps even abandoned using the results. In the early days of SF therapy (say the mid 1980s), the understandable priority was to develop and hone the approach through practice and experience. Now, twenty years later, the approach is well-established. Its implications do not appear to be well-understood, hence this paper.

We hope that we have shown how SFBT is distinctive both in terms of what is done and what is not done. In his book *Lifelines*, biology professor Steven Rose (2005) writes against the idea of genetic determinism. He summarises his position by echoing Marx and saying:

"We have the ability to construct our own futures, albeit in circumstances not of our own choosing."

SFBT echoes this idea in a very practical way. We work without psychological or systemic concepts. We embrace people as people who do things that people can do – hoping, talking, reflecting, conversing, interacting, responding... And we strive to keep on showing the benefits of simplifying.

In SFBT, the miracle is noticed after it happens. This seems to be true of many revolutions in our day-to-day lives. When computer engineer Ray Tomlinson sent the first email to his Arpanet colleagues in 1971, the papers the following morning didn't give it a mention. When SMS text messaging was added to the specification for cell phones it just seemed like a neat idea, not one that would change the way we live. Maybe the post-psychological revolution is already happening – but so far very few people have noticed it.

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References

Asen, E., Thomson, D., Young, V., & Thomson, P. (2004). *Ten Minutes With The Family: Systemic interventions in primary care*, New York: Routledge

Beavin-Bavelas J., De Jong P., & Korman H. (2008). *How co-construction happens- Formulations in SFBT, CBT and MI*. Paper presented at the SFBTA-conference Austin, Texas November 2008

Bennett, M.R., & Hacker, P.M.S. (2003). *Philosophical Foundations of Neuroscience*. Oxford: Blackwell

Berg, I.K., & DeJong, P. (1998). *Interviewing for Solutions*, Pacific Grove CA: Brooks Cole

Cilliers, P. (1998). *Complexity and Postmodernism: Understanding Complex Systems*, New York: Routledge

De Shazer, S. (1985). *Keys to Solution in Brief Therapy*, New York: WW Norton

De Shazer, S. (1988). *Clues: Discovering Solutions in Brief Therapy*, New York: WW Norton

De Shazer, S. (1991). *Putting Difference To Work*, New York: WW Norton

De Shazer, S. (1994). *Words Were Originally Magic*, New York: WW Norton

De Shazer, S., Dolan, Y., Korman, H., Trepper, T., McCollum, E., & Berg, I.K. (2007). *More Than Miracles: The State of the Art of Solution Focused Brief Therapy*, Binghamton NY: The Haworth Press

Dell, P., & Goolishian, H. (1979). Order through fluctuation. Presented at AX Rice Institute, Houston, Texas

Garfinkel, H. (1967). *Studies in Ethnomethodology*. Englewood Cliffs, NJ: Prentice-Hall

Freud, A., (1937). *The ego and the mechanisms of defence* (Cecil Baines, Trans.). London: Hogarth. (Original work published 1936)

Harré, R. (1995). Discursive Psychology, in Jonathan A Smith, Rom Harré and Luk van Langenhove (Eds.) *Rethinking Psychology*, London: Sage Publications

Harré, R. (2000). Social Construction and Consciousness, in 'Investigating Phenomenal Consciousness: New Methodologies and Maps', ed Max Velmans, Amsterdam: John Benjamin
Harré, R., & Gillett, G. (1994). *The Discursive Mind*, London: Sage

Korman, H. (1997). On the Ethics of Constructing Realities, *Contemporary Family Therapy* 19, Number 1, 105-115

Macdonald, A. (2007). *Solution-focused Therapy: Theory, Research and Practice*, London: Sage

MacKinnon, R.A., Michels, R., & Buckley, P.J. (2006). *The Psychiatric Interview in Clinical Practice (2nd Rev Ed)*, Arlington VA: American Psychiatric Press Inc

Maruyama, M. (1963). The second cybernetics: Deviation-amplifying mutual causal processes, *American Scientist* 5, 164-179

McGee, D., Del Vento, A., & Bavelas, J. (2005). An interactional model of questions as therapeutic interventions, *Journal of Marital and Family Therapy* 31, No 4, 371 - 384

Miller, G. (2003). Wittgenstein and Solution-Focused Therapy: A Misreading, *Ratkes* 1, 18–24

Miller, Scott D.; Berg, Insoo Kim (1992). *Working With the Problem Drinker: a Solution-Focused Approach*. W W Norton & Co Inc, New York

Nunally, E., De Shazer, S., Lipchik, E., & Berg, I.K. (1986). A study of change: Therapeutic Theory in Process, in Donald E Efron (Ed.) *Journey: Expansion of the Strategic-Systemic Therapies* (pp77-96), New York: Brunner/Mazel

Potter, J. (1996). *Representing Reality: Discourse, rhetoric and social construction*, London: Sage

Potter, J., & Wetherall, M. (1987). *Discourse and Social Psychology: Beyond Attitudes and Behaviour*, London: Sage

Rose, S. (2005). *Lifelines: Life Beyond the Gene*, London: Vintage

Stacey, R. (2005). *Experiencing Emergence in Organizations (Complexity as the Experience of Organizing)*, New York: Routledge

Stalker, C., Levene, J., & Coady, N. (1999). Solution-Focused Brief Therapy-One Model Fits All? *Families in Society: The Journal of Contemporary Human Services*, 80(5), 468-477

Thom, R. (1975). *Structural Stability and Morphogenesis*, Reading: Benjamin/Cummings

Wampold BE (2001). *The Great Psychotherapy Debate: Models, Methods and Findings*, Mahwah NJ: Laurence Erlbaum Associates

Watzlawick, P., & Weakland, J.H. (1977). *The Interactional View: Studies at the Mental Research Institute Palo Alto 1965 – 74*, New York: WW Norton

Watzlawick, P., Weakland, J.H., and Fisch, R. (1974). *Change: Problem Formation and Problem Resolution*, New York: WW Norton

Wittgenstein, L. (1958). *Philosophical Investigations* (tr. GEM Anscombe). Oxford: Blackwell