Classic SF Paper

Introduction to "Beyond Complaints"

Gale Miller

This essay represents the evolution of thinking about solution focused brief therapy within the Milwaukee group in the late 1980s and early 1990s. (See also the changing language of Steve de Shazer's books – 1982, 1985, 1988, 1991 – during this time.) This essay is one take on a solution focused interactional view of therapy, a view that emphasises the collaborative building of solutions. Wittgenstein's (1958) concept of language games is central to this discussion, as it continues to be today. The strong focus on goals in this essay is, however, not so emphasised in contemporary SF brief therapy conversations. While explicit goal-setting remains an option in SF brief therapy sessions, goal-setting is now recognised as an implicit aspect of conversations about the future.

Two aspects of the essay have not been significantly developed by SF brief therapy writers. The first involves exploring how SF brief therapy is a distinctive process of narrative construction. Such explorations might extend the longstanding emphasis on Wittgensteinian philosophy in SF brief therapy. The second undeveloped theme in this paper is deconstructionism. De Shazer drew on aspects of deconstructionism in *Putting Difference to Work*, but much is left to be done in this area. This is the first time this essay has been published in English.

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Beyond Complaints
A Foundation of Brief Therapy 1

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For most therapists, their therapeutic work centres on analysing, interpreting, and/or interrupting clients' complaints. Complaints are important to therapists because they are the basis for the therapist-client relationship and frequently treated as indicators of clients' problems. In analysing, interpreting, and/or interrupting client complaints, then, therapists define and attempt to remedy clients' problems. Indeed, one indicator used by therapists to assess their intervention strategies is whether clients cease or reduce their complaints. They treat the reduction or cessation of client complaints as a sign of therapeutic effectiveness and change. Finally, for most therapists, all of the above claims are common sense, they are obvious and taken for granted.

A major purpose of this paper is to propose a new orientation which treats client complaints as simply explanations of why they are in therapy and emphasises goal setting and attainment as central to solving clients' troubles. Specifically, we treat client complaints primarily as answers to the question, "Why are you here?" Based on clients' complaints, the therapist-client relationship is built, but it need not remain focused on clients' complaints. Rather, clients' initial

complaints are only one basis for constructing solutions to clients' problems. Solutions may also be constructed by defining mutually agreeable goals toward which clients and therapists are willing to work.

The details and implications of this orientation to client complaints and the therapeutic process will be further developed in the sections which follow. The major claim of the rest of the paper is that family therapists need to move from therapy practices which are complaint oriented to practices which emphasise goals. There are at least four advantages to doing so.

First, solution or goal focused therapy makes it possible to solve clients' problems in the absence of complaints. Although it is frequently assumed to be otherwise, therapists do not need clients with complaints. They need clients who are willing and able to establish goals and work toward solutions.

Second, SF therapy promises to make the therapeutic process faster and more efficient. It eliminates activities that are often treated as necessary parts of a continuous (complaint-focused) process, when therapy conversations focus on goal setting and attainment.

Third, SF therapy involves a distinctive kind of therapist-client relationship. We view the effective therapeutic relationship as a negotiated, consensual and cooperative endeavor (6, 7) in which the therapist and client jointly produce goals and solutions (8, 9). Goals and solutions are negotiated and produced as therapists and clients make sense of otherwise ambiguous events, feelings and relationships. In doing so, therapists and clients jointly assign meaning to aspects of clients' lives and justify actions intended to produce change. This view is related to our orientation to words, which is similar to that described by Mehan and Wills (15) as the dialogic orientation to language. They state that

> *the idea of competing over the meaning of ambiguous events rests on a view of language that can be understood by visualizing words in a territory or a conversational space. If one*

> *conceptualizes conversational space in a personal sense, then one concludes that individuals own meaning, own the territory. Meanings are privately assembled by a solitary speaker and transmitted to a passively receptive hearer… . If one conceptualizes words in a dialogic sense, …, then one concludes the territory is jointly owned… From the dialogic point of view, meaning is neither in the speaker or in the hearer; it is in between both: addressor and addressee… (15, p. 364).*

Finally, SF therapy is a practical approach to therapy. It is an alternative to the utopian orientation of many other therapies which treat therapists as experts. As experts, therapists try to get their clients to alter their lives and relationships to match idealised and professionally approved ways of living. In SF therapy, on the other hand, the concrete ways in which clients' lives should change is a matter of therapist-client negotiation focused on the development of mutually agreeable goals that are practical and achievable. Like the words that they use to describe their experiences and understandings of practical issues, changes produced in therapy conversations are in-between therapists and clients. That is, it is a word's use that determines its meaning.

The rest of this paper is organized around two general issues: (a) our reasons for claiming that SF therapy is more effective than complaint-centered therapy and (b) some suggestions for therapists on how to effectively participate in solution-determined conversations. The next two sections focus on the social organisation of the therapeutic process and the realities (produced as stories) that emerge in different types of therapy conversations. We argue that SF therapy involves a different orientation to the ways in which aspects of the therapeutic process are related, and encourages the development of stories that facilitate change in clients' lives. SF therapy is more effective in developing a wider range of narratives about clients' problems and their solutions, thus giving therapists and clients more options in depicting success. The second issue is taken up in the final sections of the paper where we consider how workable goals may be defined in solution-determined conversations.

Therapy as Purposeful Language Games

One way of conceptualising and describing therapy is by treating the therapeutic process as a set of related, but distinct, language games. As used by Wittgenstein (20, 21) language games are culturally shared and structured activities that centre in people's uses of language to describe, explain and justify. Language games are activities through which social realities and relationships are constructed and maintained. In therapy, one such activity or language game involves clients' explanations and justifications of their decisions to seek others' counsel and help. The activity turns on the question, "Why are you here?" However, answering this question is a different activity from answering the question, "How would you like your life to be different?" The latter question indicates entrance into a different language game, one concentrating on producing change in clients' lives.

Although the concepts dealt with in this paper (e.g., complaints, goals, and exceptions) are treated as largely separate and independent and involving therapists and clients in distinct activities or language games, each of the concepts is also related to the others. As part of doing therapy, therapists and clients link them together to produce the patterns of the cultural activity known as therapy. Further, the concepts therapists use are not as simple as they seem at first glance. Most of the concepts have no collective definition like those found in a dictionary. For instance, all complaints are not alike and not all goals are the same. No unified definition of them is possible because all examples of complaints and goals involve aspects that are absent from other examples also classified as complaints and goals.

It is equally clear that each and every example of a complaint or a goal is (in some ways) similar to others categorised with it. One complaint is similar to another in the same way that a musical variation is similar to its theme. This similarity involves "a complicated network of similarities overlapping and criss-crossing: sometimes overall similarities, sometimes similarities of details" (21, #66). Wittgenstein analyses such

similarities as "family resemblances", some of which are readily apparent, while others require extended observations and thought. Indeed, comparison of many different examples of complaints and goals is perhaps the only way to explain what is meant by various therapeutic concepts.[1]

Conceptualising the Therapeutic Process

We see the therapeutic process as centred in four loosely related language games:

- a complaint that justifies or gives a rationale for therapy,

[1] We all think we know what a game is, but it turns out that a unified definition is impossible. For instance, we might start with basketball as an example of a game. There are ten players, 5 on each side; there is a spherical ball that is either passed from one player to another or bounced on the floor until it is shot at the appropriate basket. Some shots counts for 3 points, some for 2, and some for 1, etc. Now, let's take another activity called a game: poker. A similar description would be very different, and yet we intuitively know that basketball and poker are both games. Certainly, both are similarly competitive: one team or one player wins while others lose. Solitaire is also a game, somewhat similar to poker and yet somehow very different. And then there are borderline cases: is a team practising basketball involved in a game? How about the individual in a driveway? Or the coach's chalkboard diagrams? Or hop-scotch?

Our analysis is generally consistent with Anderson and Goolishan's (1) recent programmatic statement on human systems as linguistic systems. Specifically, we also conceptualise therapy as a conversation which centres on the linguistic organisation, while we depart from Anderson and Goolishan in our focus, which is on the ways in which therapy conversations are organised to produce different kinds of problems and solutions. That is, our interest is in the concrete ways in which therapy conversations are organised and the consequences of their organisation for producing workable solutions to clients' complaints and problems. We propose an orientation that is partly designed to expand the range of stories (problem definitions and solutions) that therapists and clients may produce and consider in their ongoing conversations.

It is also intended to redirect the focus of therapist-client negotiations

- a goal that specifies how to end therapy,
- conversations that lead the client toward achieving the goal, and
- termination of therapy.

This view of the therapeutic procedure allows for the possibility that initial client complaint-making can be eliminated so long as therapists and clients develop mutually agreeable goals and enter into conversations directed toward achieving those goals. Agreement about goals and conversation about their achievement are outward and visible signs that clients' lives are changing in ways that are describable and therefore knowable by therapists and clients. Although eliciting and discussing complaints may be an aspect of a therapy conversation, effective therapy turns on the construction of describable and knowable changes in clients' lives or, more accurately, depictions of their lives. Thus, the presence of client complaints is not a necessary circumstance for doing effective therapy.

We are here arguing that effective therapy involves getting beyond complaints and focusing on goal-setting and -attainment and thus solution development. Our thesis is partly based on assessments of the practical consequences of the types of narratives that emerge from therapists' questions about and clients' descriptions of complaints versus goals.

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and story development from one emphasising the clients' complaints to the achievement of future circumstances which clients define as a-problematic and offering satisfactions not currently present in their lives (8, 9). The orientation promises to more quickly produce workable complaint definitions and solutions, a necessary context for effectively organising and solving clients' problems. Establishing goals is necessary for therapy because they are the only way both therapists and clients can know that clients' lives are different and, therefore, therapy has been successful and can terminate. Obviously, once goals are established, they can also know how to decide when therapy has failed and thus needs to terminate because it is not working.

Narrative Structure of Complaints and Goals

Although it is no longer news to therapists to say that clients' problems are defined, organised and/or constructed in therapy conversations, the centrality of problem construction in therapy cannot be overstated. Sensitivity to this aspect of therapy conversations is central to the production of cooperative therapist-client relationships in which therapists act as co-producers of clients' complaints, not as experts who have the right to impose their definitions on clients. But it is necessary to get beyond this observation and consider how clients' complaints are interactionally constructed in therapy.

A useful framework for dealing with these issues is offered by narrative psychologists who emphasize the ways in which social realities and actions are constructed as stories. They analyse the ways in which persons use story constructing and telling conventions to link events and give them meaning.

As Sarbin (16) states:

> *a story is a symbolized account of actions of human beings that has a temporal dimension. The story has a beginning, a middle, and an ending [or, …, the sense of an ending]. The story is held together by recognizable patterns of events called plots. Central to the plot structure are human predicaments and attempted resolutions (p. 3).*

Stories are not best understood as true or false, but as formulations and expressions of people's orientations to practical matters. Viewed this way, therapists' and clients' stories are subject to change within and across situations as they negotiate and deal with the practical issues emergent in their conversations. Indeed, the discontinuities and transformations in discourse and meaning may be understood as changes in therapists' and clients' story telling activities. Such changes partly involve the development of new "plots"; that is, new depictions of events which are linked together to produce new patterns and meanings. It is through their depictions of events as aspects of larger patterns that therapists and clients construct clients' lives

and problems. Further, in developing new plots, therapists and clients recast the predicaments of clients' lives and their attempts to manage them.

One of the advantages of conceptualising therapy conversations as story construction and telling is that it allows us to compare and evaluate the narrative structures of different types of therapy conversations. Specifically, we may ask, are some types of story construction more likely to result in change than others? Our answer is yes. We believe that therapeutic narratives focused on the setting and attainment of workable goals are more effective in producing change than those focused on clients' complaints. Specifically, solution-determined narratives are more likely than complaint-centered narratives (the major form of therapeutic story construction) to produce transformations and discontinuities.

According to Gergen and Gergen (11, 12), story construction is partly an evaluative activity focused on such questions as "Is she a good or bad person," "Is he getting better or worse," and "Am I really achieving what I want?" Such questions require that people assess and describe their lives and those of others across time. They must link otherwise discrete events into patterns that can be used to produce and justify their conclusions that the issues at hand are better, worse or the same. Thus, Gergen and Gergen conclude that there are three narrative types available to people in describing and evaluating their own and other people's lives. These are:

a progressive narratives that justify the conclusion that people are progressing toward their goals,
b stability narratives that justify the conclusion that life is unchanging, and
c digressive narratives[2] that justify the conclusion that people are moving away from their goals.

[2] Gergen and Gergen (11, 12) use the term "regressive", but by using "digressive" we want to emphasise the movement away from the goal.

Analysis of therapeutic conversations as progressive, stability and digressive narratives is useful for assessing whether desired change is occurring. Clearly, stability narratives are problematic for therapists and clients because they signal and are sources for lack of change in clients' problems and lives. Although progressive and digressive narratives involve change, they have very different implications for therapy conversations. Progressive narratives signal and are sources for producing desired changes while digressive narratives involve undesired changes. Indeed, as Gergen and Gergen note, digressive or regressive narrative structure is central to the telling of tragic stories which focus on people's movement away from their desired life circumstances.

Therapists' concerns and responsibilities in therapy conversations also vary depending on the types of narratives or stories that dominate in their interactions with clients. Their major concern and responsibility in conversations dominated by stability and digressive narratives is to help clients construct new stories that signal and are sources for desired change. The development of such stories involves transformations in therapists' and clients' discourse.

Therapists' major concern and responsibility in therapy conversations dominated by progressive narratives is to help clients elaborate on and "confirm" their stories. Therapists may do so by pointing to ways in which clients are attaining their goals and helping them develop new and related goals that involve further change in their lives.

Goals and Solutions

Without clear, concise ways to know whether it has either failed or succeeded, therapy can go on endlessly – which at times means that therapist and client succeed without their knowing it. Regardless of what else may result from it, a therapy conversation that is unending is a partial failure because one goal of

therapy should be to resolve clients' complaints and terminate therapy as quickly as possible. Early in their conversations, therapists and clients must address the question, "How do we know when to stop meeting like this?" Both clinical experience and research indicate that workable goals[3] tend to have the following general characteristics: They are

1 small rather than large
2 salient to clients
3 described in specific, concrete behavioural terms
4 achievable within the practical contexts of clients' lives
5 perceived by the clients as involving "hard work"
6 described as the "start of something" and not as the "end of something"
7 treated as involving new behaviour(s) rather than the absence or cessation of existing behaviour(s).

Our view that solution-determined conversations are more likely to result in desired change involves the types of narratives associated with complaint- versus solution-focused therapy. Complaint-centered conversations focus on clients' dissatisfactions with aspects of their lives. The goals and solutions produced in such conversations emphasise the cessation of the unsatisfactory aspects of clients' lives. The tone and focus of such conversations is on the reasons why clients are unhappy, a circumstance that allows for and may even encourage digressive and stability narratives. Put differently, conversational focus on clients' complaints is unlikely to result in clients' developing new stories about and orientations to their lives. Clients are likely to use such conversations to "confirm"

[3] Although the concepts of goal setting and goal achievement are often thought of as rather lineal, we are using them in this systemic construction as a way to attempt to promote change and elicit news of change and solution. Within our framework, multiple, interactional, and situational goal statements that describe the "who, what, when, where, and how" of solution are more desirable than one single targeted behavioural goal statement.

and justify their initial claims that their lives are dominated by complex problems that get no better or are getting worse. Clients may also use complaint-centered therapy conversations to produce new complaints and problems, thereby making their lives more tragic and unsatisfactory.

The goals produced in complaint-centered therapy conversations are largely negative, focusing on how to eliminate undesired behaviours and relationships. These conversations are not negative because they are morally bad or professionally irresponsible, but because they centre in clients' giving up or casting out the unsatisfactory aspects of their lives. An alternative and more positive focus involves describing the solutions to clients' problems as building new lives that centre in new behaviours and relationships. Clients' future lives do not include their old problems because the new behaviours and relationships will replace them. The solution to clients' problems is described as working toward new, more satisfactory lives.

Although it is a simplistic example, the difference in focus and tone between complaint-centered and solution-determined conversations is partly reflected in our orientations to the prospect of giving up smoking because it is bad for us versus taking up jogging and, in the process, ceasing to smoke because it reduces our ability to achieve our new, jogging goals. This example is useful because it illustrates how solution-determined conversations produce social conditions encouraging therapists and clients to construct progressive narratives[4]. The SF question is not, "have you given up smoking yet," but "how's your jogging coming along?" "What difference has your jogging made to your wife?" Certainly the latter questions do not guarantee a "happy ending" to the therapy conversation, but they do involve a different orientation to the interaction and sense of the social conditions signalling the end of the therapeutic relationship.

[4] What aspects of the conversation the therapist deems worth paying special attention to is determined by the progress toward a solution.

Solution-determined narratives (or language games) are associated with a future orientation that involves more than the elimination of clients' complaints. The narratives also highlight the variety of ways in which clients can change their lives to achieve their diverse ends. They open therapist-client interactions to a wide range of solutions and changes that may be only vaguely or not at all related to the complaints initially used by clients to explain their involvement in therapy.

Defining Workable Goals

In the ideal circumstance, well-formed goals are defined in therapy conversations. Such goals have the characteristics of workable goals noted above. Most importantly, they are achievable by clients, mutually agreeable to clients and therapists, and describe how clients and therapists will know that the problem is solved. Not all client goals can be described as well-formed, however. This does not mean that clients and therapists cannot develop ways to know that clients' lives are changing in satisfactory ways. It only requires that therapists help clients develop descriptions of their problems that can be treated as goals. For example, scaling operations can be used to help both clients and therapists know when therapy is finished.[5]

The observations and suggestions that follow apply to clients who enter therapy conversations with complaints. The

[5] Specifically, "10" can be used to stand for the "worst" the problem has ever been and "0" to stand for the "feeling state" on the day after the problem is solved. The number assigned by the client to the feeling state on the day after the problem is solved becomes the goal. Therapists and clients can now consider how to achieve the goal. During each subsequent session the client is asked to rate himself or herself on the scale (without being reminded of previous ratings). Thus, movement toward the goal state can be assessed as clients rate themselves in each session. Once there is a rating of "5" or lower, then a new scale can be introduced with "10" used to stand for "no confidence that "0" on the feeling state scale will be

major concern of therapists in such conversations is to help clients define goals that allow them and their clients to know when clients' problems are solved. The observations and suggestions focus on three interrelated conversational activities:

1 imagining and describing new lives for clients,
2 producing exceptions in clients' lives that point to desired changes, and
3 "confirming" that change is occurring.

Through these activities, therapists and clients produce progressive narratives which focus attention on the ways in which clients' lives are getting better and problems are being solved. The narratives end with the termination of therapy. Finally, a major objective of therapists should be to help clients construct the narratives as "short stories" not "Tolstoyesque novels".

Imaging and Describing New Lives

Most clients describe and orient to their lives and troubles in restricted ways, focusing on problematic aspects of their

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reached" and "0"standing for as much confidence as is humanly possible. When both are below "5", then the solution is "right around the corner". Of course, it is possible to have situations in which no goals can be deve1oped. Without goa1s for therapy, there is no contract and, therefore, there is no way to know that therapy is finished. The therapist in this situation needs to wonder if there is need for therapy. In most situations without a goal, the client has no reason to be in therapy except that he or she is being sent by controlling authorities, such as probation officers or judges. The referral source has the complaint, not the client, and without the client having a goal therapy cannot begin. Even "getting the p.o. off my back" can be developed into a workable goal and therapy can start. But, if no goal emerges in the therapy conversation, then the therapist must decide whether to continue or send the client back to the referral source.

lives. They rarely describe the solutions to their problems as part of a process of producing new lives. For example, clients frequently state their goal for therapy as "not being depressed anymore", or to "stop fighting", or to "not steal anymore". That is, they describe their goals in terms of the absence of negative or undesirable behaviours without giving much thought to what might replace the troublesome behaviours involved. The task for therapists in these conversations is to help clients describe and orient to their problems in new ways. They must help clients enter the language game of goal definition, thereby creating social conditions for producing progressive narratives and change.

To some extent, at least, what one expects to happen shapes what actually does happen (2, 3, 4, 6, 8, 9, 10, 18). For instance, simply imagining the successful elimination of premature ejaculation and describing that future success, both interactionally and in great detail, can be seen as creating the expectation of success and thus as creating a map for the future (6). Imagining a certain event (including one's own behaviour as well as the behaviours of the others involved) can lead to the prediction of that event and such predictions help to determine subsequent behavior (13). It is as if a prediction about one's behaviour and the behaviour of others in a specific situation leads to a script or a plan or a map or a vision of the behavioural sequences in that situation. Subsequently, when the imagined situation is at hand, the same vision will be used to guide one's behaviour (6, 10, 13, 17).

In 1984, we invented a way to promote a "hypothetical solution" depicting that we call "the miracle question" (9). This question, or rather series of questions, is used to aid in this crucial task of goal setting. It is based on the crystal ball technique (6, 8, 10), developed from the work of Milton H. Erickson. In its original form, this technique involved the clients', while in a trance, gazing into crystal balls and projecting themselves into some future in which the problem is experienced and described as already solved. At BFTC this technique takes the form of a simple question: "Suppose that

one night there is a miracle (or, suppose that a fairy godmother came with a magic wand) and while you are sleeping the problem that brought you into therapy is solved: What will you notice different the next morning that will tell you that there has been a miracle? What will your spouse notice?"

These questions are extremely helpful in establishing goals in as concrete, clear, and specific a manner as possible. It asks clients to get beyond their immediate complaints and imagine a future life that is satisfactory. It also encourages clients to orient to their current problems in new ways, as temporary circumstances that need not always be part of their lives. Thus, getting clients to imagine that the miracle has happened has powerful implications for clients' understandings of their problems and need to do something different. The MQ is also a basis for eliciting from clients concrete, behavioural descriptions of how they wish their lives to change. The descriptions are therapeutic goals for assessing clients' efforts to change and knowing when their problems are solved.

Since the responses to the miracle question frequently describe the solution in rather detailed, interactional, behavioural terms, a logical therapeutic task is to get the clients to initiate those behaviours. When there are no models or precursors for those behaviours, a task can be built around pretending as if the miracle has happened already, usually starting with the simplest, easiest or smallest among what they have listed. When there are precursors (i.e., exceptions to the complaint), then a task can be built around doing more of what is already working.

Producing Exceptions/Precursors

There are traditions in both Eastern and Western philosophy that treat change as a continuous process – not an event. In fact, the Buddhists will say that stability is an illusion, a simple memory of the way things were at a specific moment in the past. However, adopting the Buddhist view of change

does mean new ways of doing therapy. At the Brief Family Therapy Center (BFTC) for instance, we find that when asked in the right way or at the right time – 67% of our clients are able to describe times when the complaint is not happening but should be (these times are called "exceptions"), and when asked in the right way – 67% of our c1ients are able to describe things that have changed for the better in the interval between their initial telephone call setting up therapy and their the first session (called "pretreatment change", which is another type of exception). Sometimes these differences will be exactly of the type they were seeking from therapy in the first place (19), and thus increasing the frequency of the exception pattern leads to the development of the solution.

In some ways, doing therapy involves the therapist and client in applying the philosophy of language to the use of language. Following Jacques Derrida (5), any concept, even and particularly family resemblance type concepts, always already carries the seed of its deconstruction. For instance, the concept of problem implies another concept, non-problem. As client and therapist talk about the complaint, i.e., drug addiction, which means that taking drugs is involuntary, any mention of not taking drugs when drug taking is expected makes the concept of addiction (an attribute of this problem) into an undecidable that begins the process of deconstructing the problem and the concept of problem. Of course the undecidable always already initiates the language game of solution construction because the exception, i.e., not taking drugs, is an attribute of the solution and of the concept of solution.

At times, however, the conversation can be so vague that the therapist cannot understand what are the attributes of a complaint and what are the attributes of an exception. In a complaint-centered conversation, this is more problematic than in a solution-determined one. Again, following Derrida (5), the vagueness can be seen as an attribute of an already deconstructed complaint and, therefore, since what is complaint and what is non-complaint is "undecidable",

beginning the goal setting language game gives meaning to the situation. (However, when the therapist and client construct vague goals, maintaining a progressive narrative is more difficult because, again, any attribute might be goal-focused or it might be non-goal focused. Thus the therapist needs to conduct a vague conversation that leads the client to construct meaning by seeking clarity from the therapist.)

Where previously we saw exceptions mainly as they related to the clients' complaints, we now see exceptions primarily as precursors to goals and solutions. That is, times when the complaints are unexpectedly absent can be seen as a) times when the goal-state is approximated and/or b) the raw material for constructing the solution. It is our assumption that, in most cases, part of reaching a solution involves increasing the frequency of exceptions and increasing the significance of the exception for clients. This is possible because, for most clients, the complaint does not always happen, although at the start of therapy these exceptional times are not yet seen as differences that make a difference. Even when clients are able to describe these exceptions – times when the complaint is unexpectedly absent – as happening fifty per cent of the time, they still perceive the problem pattern as the dominant one. In these situations it is the therapist's task to help the client construct a new reality in which the exceptions are seen as differences that make a difference.

Once the conditions associated with exceptions are described, then an increase in the frequency of these conditions will "automatically" lead to an increase in the frequency of the exceptions, and a solution pattern will evolve. For this approach to be effective, the exceptions and their associated patterns need to be described in a way that the client will be able to intentionally perform the behaviours involved. For instance, if overcoming the urge to use cocaine is associated with going for a walk or telephoning a friend, then these behaviours can be suggested or even prescribed as aids to overcoming the urge to use coke. Obviously, the wider the client's repertoire the better.

Even though the client is able to richly describe the

patterns associated with the exceptions, sometimes he or she has very little confidence in this approach actually leading to a "real" solution. After all, these steps seem very small in the face of their view of the problem as overwhelming and beyond control. This lack of confidence can frequently be remedied through the process of goal setting. Specifically, therapists should encourage clients to describe the "hypothetical" solution pattern in detailed and comprehensive ways. One purpose of this emphasis is to encourage clients to see that change is possible and small changes are parts of larger patterns of change. In other words, such descriptions empower clients, increase their confidence that change can occur, and make it more likely that they will predict success.

Randomness, Spontaneity and Chance

Sometimes, exceptions are described as occurring randomly and therefore the client sees them as flukes or chance events, the occurrence of which is beyond their control. Thus, every time the complaint does not happen it comes as a surprise, and exceptions – no matter how frequent – are not perceived as models upon which to build solutions. Client portrayals of exceptions as surprises and flukes are central to their construction of stability and digressive narratives. By describing exceptions as unimportant and beyond their purview, clients fail to "see" and consider events that may be treated as evidence that their lives are getting better. In such cases, therapists must help clients "see" the events as exceptions, thereby transforming their understanding of their life circumstances and discourses about them. For instance, some clients find it difficult, if not impossible, to describe how they overcame the urge to act depressed on a specific day or how, on a specific day, they overcame the urge to drink too much. However much this description implies control, it is difficult to prescribe these undescribed conditions surrounding the exceptions. It is even more difficult for the client to have any confidence in his or her ability to repeat the exceptions – no matter how frequent they have

been. This is the problem of randomness. Wittgenstein (22) summarizes it in the following way:

> *If I now assume there could be a random series, then that is a series about which, by its very nature, nothing can be known apart from the fact that I can't know it. Or better, that it can't be known (# 145).*

Predicting Randomness, Spontaneity and Chance

(We will again here follow Derrida (5).) When there is a problem or complaint that brings the client to seek therapy and, as is usually the case, the client describes the complaint as involving behaviours that are predictable, and the therapist and client are able to describe an exception that happens randomly or by chance, then there is an unpredictable exception. The meaning or concept of the complaint becomes undecidable when the client is asked to predict the exception, because this means that the therapist is suggesting that the presence of the exception is predictable. When the presence of the exception is seen as predictable then the presence of the complaint is at least implicitly seen as unpredictable.

It is reasonable that before therapy begins the client would predict that the problem is going to happen rather than the exception because the exception is seen as beyond control. However, there is no reason for the therapist to assume that exceptions are any more subject to chance than any other behaviour, whether problematic or exceptional. Rather, it seems best to assume that these "random" exceptions are not random and are indeed embedded in certain as yet undescribed patterns which, if described, would allow for their being prescribed. It seems clear that the client (and the therapist) can both safely predict continuation of the problematic behaviour. It also seems safe to assume that the hit or miss occurrence of random exceptions can also be predicted, even though any specific occurrence of the exceptions appears beyond prediction.

All this seems common sense: "random" exceptions are

not really random, they are just described as if they were because the conditions which would allow us to predict them are unknown. What does not seen common sense is that predicting exceptions tends to increase the frequency of the exceptions. For instance, asking a client "to each day predict whether you will overcome the urge to do coke the following day and then, at the end of the day, see if your prediction turned out right, and then account for how come your prediction turned out right or wrong", most frequently will lead to a reported increase in their overcoming the urge to do coke, even though the pattern involved remains undescribed.

The task of predicting random exceptions is designed to create a self-fulfilling prophecy. That is, predicting an atypical situation (i.e., overcoming the urge to act depressed) can lead to behaviours that increase the likelihood of the exception which changes the typical situation (i.e., acting depressed) into an atypical one (i.e., acting un-depressed). It is as if the client knew all along what the elements of the exception pattern were, but was simply unable to describe them. It is as if the prediction of the exception triggers the exception pattern itself, even when the client remains unable to describe this pattern in subsequent sessions. It might be best to see predicting exceptions as if these were predictions of the whole pattern surrounding the exceptions – even when the pattern remains unknown.

Confirming Change in Clients' Lives

Solution-determined language games necessarily result in stories that are designed to confirm whether or not satisfactory change has occurred and/or is ocurring[6]. Beginning with the

[6] From a different discourse: During a follow-up study at BFTC (14), at six months after termination (n =164), 80.37% of clients said that they had either met their goal for therapy or had made progress toward their goal. The average number of sessions was 4.7 and the overall average at BFTC is 4.5 per case (for the most recent 3000 closed

second session and continuing until the final session, the primary conversational activity focuses around the question "What is better?" Like all other therapeutic concepts, "better" is a family resemblance type of concept (20, 21) and the best way to answer the question is by pointing to a series of examples and, therefore, the therapist will open the interview by simply asking the client "What is better?" In this way, the range of possible responses is expanded to include anything and everything the clients view as making their lives more satisfactory. Clear cut criteria for both success and failure can be difficult to establish because they are not entities or specimens.

These classifications are like the classifications made by philosophers and psychologists which are like those that someone would give who tried to classify clouds by their shapes. (22, #154). Both success and failure are difficult to define and describe except by pointing at a series of examples or by developing somewhat arbitrary operational definitions. Obviously, when the goal was well-formed, then determining what kind of examples of success clients and therapists can point to that will allow them to terminate is a relatively simple matter.

When a complaint served to originally organise the therapy conversation, then the elimination of the complaint serves to end that particular language game. Depictions of new and different behaviours and depictions of new or different perceptions in place of the complaint's behaviours and perceptions serve to confirm the end of this language game and the solution-determined (i.e., goal-achievement) language game. When exceptions were produced, then a successful termination narrative includes a description of an increase in the frequency of the exception and, ideally, the description of the exception that has become a new "rule" in the clients' new, more satisfactory life.

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cases). With 4 sessions or more, 91% reported success, i.e., met their goal or made significant progress, and 62% (of 123 asked) reported meeting an additional, secondary goal, while with 3 sessions or less that drops to 44% who said they met a secondary goal. 76% reported no "new" problems had developed and 66% reported improvement in other areas.

Goals and goal achievement provide a major theme around which clients and therapists organize descriptions of change and solution. Once the clients are confident that the goal has been achieved and that the changes involved are likely to continue, then both therapists and clients can know that they can stop meeting. At times, clients will depict their lives as "better" and be able to describe changes in behaviour and/or perceptions that were not part of previous conversations about complaints, exceptions, and goals. Nonetheless they will maintain that things are "better enough" and that their new lives are satisfactory enough for therapy to terminate. Sometimes they are even willing to place a wager on things continuing to be better enough so that therapy can terminate. Although at first glance this is a puzzling and enigmatic story, it should not be seen as a surprise ending and therefore rejected by therapists.

Clients' descriptions of complaints, exceptions, and goals are products of the interaction between therapists and clients and therefore what the clients see as worth describing is somewhat influenced and shaped by the therapists' part in the dialogue. Perhaps the conversation was not wide enough to include the full range of behaviours and perceptions that had the potential to help the clients make their lives more satisfactory. In this situation it is perhaps best to think of even concrete and specific goals as names for members of same larger class that includes other un-named members which the clients can find equally satisfactory. Perhaps clients and therapists alike cannot know what problem they are solving until they know what goals they reached. As Wittgenstein put it, "only where there's a method of solution is there a problem" (22, #149).

Sometimes, clients will have met their concrete and specific goals for therapy and yet remain unsatisfied. They are able to describe changes, i.e., they desire difference in their life and yet the difference does not make any difference. How is this situation to be considered, success or failure? On one hand, as long as the goals were small, concrete, reasonable, etc. and these goals were met, then therapy needs to be considered successful. On the other hand, as long as the differences do not make a difference to the clients, then the therapy conversation

needs to be considered a failure. A clear-cut failure involves both lack of goal achievement and lack of client satisfaction, i.e., when the therapist asks "What is better?" the client persistently and insistently maintains a depiction of life where nothing is changing, nothing is better.[7]

Conclusion

In part, this paper is an extension and elaboration of emerging constructivist ideas about doing therapy. The approach challenges formerly dominant notions about the ontological status of clients' problems and their solution. Therapists no longer accept without question the claims that clients' problems are "facts" that may be objectively discovered through systematic observation or that there is only one right way to describe and solve clients' problems. The constructivist approach is also one basis for new orientations to therapists' professional roles and relationships that emphasize cooperative therapist-client interactions. Most generally, this paper extends and elaborates on the constructivist approach by treating therapy conversations as story – constructing activities that involve both therapists and clients.

But the approach to therapy discussed here is more than a simple extension and elaboration of the constructivist approach. It also offers rationale and procedure for developing a new orientation to therapy, one focused on solution development through goal setting and attainment. As the title states, we believe that it is time for therapists to get beyond complaints and focus on producing conditions that make solution possible (i.e., that make progressive narratives possible). Clearly, listening to clients' complaints is a necessary aspect of many therapy conversations, if for no other reason than because clients expect and sometimes demand to express their complaints. However, just as other conversations involve

[7] Re-focusing conversations toward solution when failure seems "right around the corner" is beyond the scope of this essay, but this situation is dealt with by Berg, I.K. and de Shazer in their forthcoming book.

aspects that are important, but not central to interactionists' purposes and goals, so complaints are important, but not central to therapy conversations. What is central is the solution of clients' problems in ways that are satisfactory to clients and therapists. We believe that solutions are most quickly and effectively developed when therapists and clients first develop goals that simultaneously define acceptable solutions to clients' problems and point to the ways in which they can be achieved. Focus on goals and solutions promises to transform clients' discourse about their lives and problems and therapists' discourse about their contributions to therapy conversations.

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