

SFBT 2.0: The next generation of Solution Focused Brief Therapy has already arrived

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Abstract

This paper seeks to consolidate developments in Solution Focused Brief Therapy (SFBT) over the past decade. I conclude that we have already seen the arrival of a kind of new form of SFBT, focused firmly on descriptions and even simpler in form than the original SFBT developed by Steve de Shazer, Insoo Kim Berg and colleagues. This new form is still definitely SFBT in terms of the priorities and focus of the original progenitors, but it has also left behind many elements which were inherited during the initial development from the previous family therapy and brief therapy traditions. The name 'SFBT 2.0' is proposed, to help prevent confusion with earlier forms while maintaining that this is not a new therapy but an important evolution of existing practice.

Introduction

In Solution Focused Brief Therapy (SFBT) the question “how would you notice that the miracle has happened” is often asked. This is not at all the same as how to make the miracle happen – more like beaming ahead into the future and exploring the difference that the miracle makes in everyday life. It leads to a conversation about noticing change, rather than striving for it from scratch - about discovering that change is already happening as a precursor to building on it.

I suggest that the signs of such a change in our own practice are becoming more and more noticeable. In this paper I will outline these signs and how I think that they are showing that we are already proceeding in new directions. As such, this paper is not a call to action. I am not proposing a new form of SFBT, I am trying to give more clarity and shape to what is going on, and propose that it's time for us to recognise and use these developments rather than pretending that we are all still on the same page from the early 1990s. These latest versions are already in print, but they are not clearly flagged as new. That there are different forms of SFBT under the same banner risks causing confusion among newcomers, and indeed among more experienced practitioners who see different ideas and methods under the same title.

As these newer versions are still unmistakably SFBT, it would not be appropriate to seek to give them a new name. However, there is now enough difference that it would be worth making a distinction. In the manner of major new releases of software, I propose that 'SFBT 2.0' might be a working title.

In this paper I will seek to describe the differences and innovations between SFBT 2.0 and what we might call SFBT 1.0, the 'original' version. Even this is not easy to pin down in detail, following Steve

de Shazer's insistence on many occasions that 'there is no orthodoxy'. However, these distinctions are becoming larger and increasingly important, and the field is at risk of becoming even more muddled.

SFBT 1.0

SFBT emerged gradually during the second half of the 1980s from an extensive programme of empirical research at the Brief Family Therapy Center (BFTC), Milwaukee under the direction of Steve de Shazer, Insoo Kim Berg and colleagues. De Shazer and Berg were highly influenced by the brief therapy approach of the Mental Research Institute (MRI), Palo Alto, and set out to develop this approach in their own centre. Indeed, MRI stalwart John Weakland remained both supervisor and close friend to Steve de Shazer until the former's death in 1995. This background is important in the way language is initially used in SFBT, as we shall see.

Through the first half of the 1980s the BFTC team developed their brief therapy ideas, with Steve de Shazer producing two books (S de Shazer, 1982, 1985) building on the idea of finding patterns and developing ideas based on Ericksonian methods (for example the 'crystal ball technique') developing interventions which could be seen as 'skeleton keys' to unlock cases. The first traces of SFBT as we know it appeared in a key 1986 paper (de Shazer et al., 1986) and consolidated in the 1988 book *Clues: Investigating Solutions in Brief Therapy* (de Shazer, 1988). Gale Miller, engaged by BFTC as an observer/researcher, spent time at the Center in 1984 and again from 1989. He says (McKergow, 2009) that the practice changed markedly during this time:

Keep in mind that in 1984 they were not doing SF therapy, they were doing something very much like Steve's first book (de Shazer, 1982) – I called it ecosystemic therapy. It was very much informed by the Palo Alto Group (the Mental Research Institute)... [In 1989] I discovered that it was a very very different place. You could see that they had made a dramatic move in the direction of SF practice, different kinds of assumptions, much less systemic, much less time on developing clever interventions, much less time mapping troubles or problems, it was much more focussed on solutions and more fluid. (p.79)

Many practitioners around the world recall starting their SF practice by reading *Clues*, which contained the main ingredients of SFBT (although not with the same balance of elements – much more emphasis is given to constructing exceptions, with conversations around a hypothetical solution reserved for cases where no exceptions can be found). Steve de Shazer went on to write two books which were less about the 'how to' than attempting to add some intellectual rigour to their findings (de Shazer, 1991, 1994). By the early 1990s the approach was gaining a foothold internationally, and the formation of the European Brief Therapy Association (EBTA) in 1994 gave a place for practitioners to gather, share and develop.

Developments through the 1990s and into the 2000s included more focus on research (and the development of an EBTA research protocol to try to ensure some clarity about what counted as SFBT for research purposes), and the application of SFBT ideas in further areas of therapy and of life (schools, organisations, social work, prisons, etc). Through the first decade of the 2000s there were hundreds of research studies published (Macdonald, 2011), and in 2011 an authoritative collection was curated by Cynthia Franklin and published through Oxford University Press (Franklin, Trepper, McCollum, & Gingerich, 2011). The second chapter of this book (Trepper et al., 2011) is entitled

'Solution Focused Brief Therapy Treatment Manual' and gives a good description of what we might call 'classic SFBT'.

- Pre-session change
- Goals (preferably small)
- Miracle question
- Scaling questions
- Constructing exceptions
- Coping questions (if appropriate/necessary)
- Break, compliments about strengths and resources
- Homework (either designed by client or experiment suggested by therapist)

This summary will serve as a base line for what comes next. I don't think there is anything controversial about it as a broad statement of practice.

Emerging developments

During the 2000 and into the 2010s there have been some interesting developments emerging in the SFBT field which seem to me to extend and change the classic SFBT 1.0 treatment manual given above. Many of these developments are mentioned, without too much ceremony, by Shennan and Iveson (2011) and indeed in other works from the BRIEF team and others (Iveson, George, & Ratner, 2011; Iveson & McKergow, 2016; Ratner, 2014; Ratner, George, & Iveson, 2012). However, in some cases I fear that the authors have not made enough effort to distinguish their own innovations from established practice. I would summarise the distinctions as:

- From action language to description language
- From questions to 'rooms' and 'tools'
- From goals to best hopes/common project
- Preferred futures and scales – same questions, different aims
- From exceptions to instances – clearer focus on discussions about the past and present
- Losing hangovers from family therapy
- Ending the session – no tasks or even actions, more appreciative summarising

Let's look at each of these in turn.

From action language to description language

From the earliest days, MRI model brief therapy valued specific concrete descriptive information (see Weakland & Fisch, 1992 for a latter day summary, which also states that Steve de Shazer attended an early MRI brief therapy workshop in 1972). The MRI approach, a real paradigm-buster in mental health, is to view such problems not as 'inside' the patient but as some kind of result from the communication patterns between the client and those around them. The focus on specific concrete descriptive information is a way to stop being drawn in to internal psychological hypothesising, and instead focus on the interactions – who is doing what, with whom, when and in

what order. This, in the MRI model, is the key to finding ways to disrupt the pattern which is maintaining the problematic state and opening the doors for something different to happen, by devising a behavioural intervention. Once something different IS happening, the client can be advised to do more of it to promote the new and better pattern of behaviour.

This focus on specific language is carried over into SFBT 1.0. Indeed, de Shazer and others consciously named their landmark paper *Brief Therapy: Focused Solution Development* after the MRI's earlier contribution (Weakland, Fisch, Watzlawick, & Bodin, 1974), as a way of indicating that these two approaches were connected. However, this concrete detail is now much more about what the client wants, the day after the miracle, what is working and so on, rather than about the problem pattern. The overall purposes of both avoiding mentalistic hypothesising and focusing on specifics are still there, as is the focus on gathering information with the goal of devising interventions or giving tasks.

If we look now at the recent 'descriptive turn' described by Shennan and Iveson, this same focus on specific concrete descriptive information is present. However, now this detail is not for the therapist to devise interventions, it's much more for the client to say and hear and respond to. If anything, the level of detail is even greater than before – for example, the 'cuddle' case related by Iveson and McKergow (2016) where a five-second cuddle takes as many minutes to describe. (Sharper eyed readers may have noticed that the title of their paper, *Brief Therapy: Focused Description Development*, consciously echoes both the papers mentioned in the previous paragraph, again in tribute to an evolving approach.)

The goal of the therapy is changed here. The therapist is not seeking to gather information to devise interventions. Rather, the therapist's role is to help the client expand the details of their descriptions, which then become more and more littered with tiny specifics which might easily suggest themselves as actions for the client. Once the client is talking, say, about the day after the miracle, the therapist will be encouraging more detailed talk about the client and those around them (a very conscious echo of the MRI half a century ago) but in terms of details of what the client wants rather than the problem patterns. Some very simple questions can help this, such as

- What would be the first tiny signs you would notice that [X] was starting to happen? What else?
- Who would be the first person to notice that [X] was happening? What would they notice, that would tell them that [X] was happening? What else?

Note that [X] doesn't have to be specific here – it might be a simple restatement of best hopes, or even just 'this' in the conversation. These questions help render things detailed, even from very foggy and unclear starting places.

So, the role of therapist changes from a sorter-of-detail (to figure out the relevant details for intervention design) into an expander-of-detail (to help the client immerse themselves in their descriptions of better futures, pasts and presents). The vocabulary shifts from 'doing' to 'noticing'. It seems that Steve de Shazer and Insoo Kim Berg were onto a part of this shift of emphasis as early as 1992 in their paper *Doing Therapy: A post-structural revision* (de Shazer & Berg, 1992) where they discuss the idea of grammar-shifts during the session. However, they may not have grasped all the

consequences of such a shift at that time. This new role also comes into play in many of the other distinctions I will relate below.

From questions to 'rooms' and 'tools'

Questions have always been at the heart of SFBT. Indeed, the original videos produced by BFTC showing Steve de Shazer and Insoo Kim Berg at work are subtitled to help viewers keep up with what's happening in the session. The titles say 'Miracle Question', 'Scaling Question' and so on. The focus is on the question. There are now even books collecting huge numbers of 'SF questions' even now books about '1001 SF Questions' (Bannink, 2010), as if a question alone can be 'solution-focused'. (Any question can be asked in a myriad of different ways, and only some of them might be SF.)

Of course such questions are an important element of SF practice. However, the point of these questions is not simply to be asked – it is to start or build on a section of the interview/session. A miracle question and a single answer may make a little progress, but the real meat lies in what happens next – the expansion of the answers into descriptions in conversation.

The miracle question or scaling question is not simply a question, but the start of a much longer piece of conversation. It therefore makes sense to focus on these chunks of conversation, rather than the questions alone, as discrete elements. So, a 'preferred future' conversation is a miracle question PLUS all the follow ups about first tiny signs that the miracle has happened, who else might notice, what would they notice, what happens next, what difference that makes, to whom, and so on.

Chris Iveson has been talking about an 'art gallery' metaphor for a therapy conversation. This art gallery has a series of 'rooms' with different things to look at and examine. These rooms might include (Figure 1):

- Ticket office – getting some best hopes from the client, a 'ticket' to proceed with the work.
- Preferred future gallery – a set of pictures or descriptions of a better future for the client and their kin (wrong word) with these best hopes realised
- Instances gallery – a set of pictures or images of instances in the past or present that connect with this preferred future (which may be constructed using a scale from 1-10)
- Gift shop – the final room, which may feature a series of pictures or images of N+1, smaller pieces or signs along the way that progress is being made.

A solution-focused art gallery

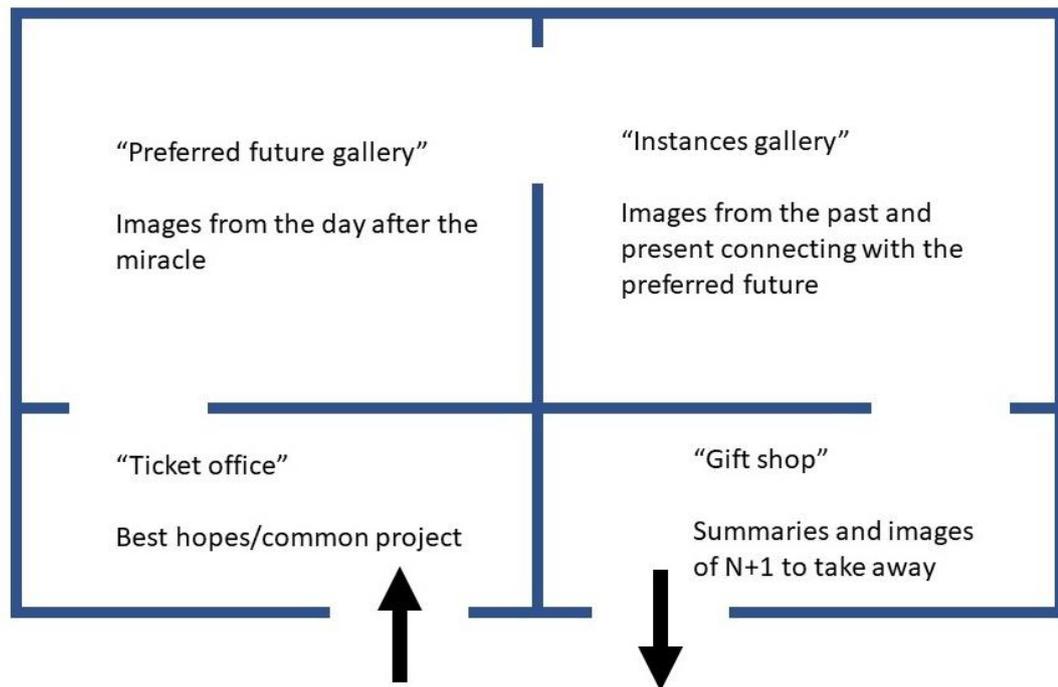


Figure 1

A solution-focused art gallery (after Chris Iveson)

Like the Instances gallery, Adam Froerer of Mercer University talks of a Resources room (Froerer, 2017), where different elements of the client's life showing their resources are gathered. The point of this metaphor is not that each room must be visited in order with no backtracking allowed. Far from it – although there is definitely a direction of travel implied from entrance to exit, during the session the client and therapist may spend more time in one room than in others, may go back and revisit something, or perhaps discover something else they hadn't noticed before, and so on. This is not a recipe but a guide to what will inevitably be an individual journey.

These 'rooms' help the practitioner keep track of where they are and what's going on in the conversation. It's generally good to stay in one room for a while, not dashing frantically from one room to another. If, during a preferred future conversation, an interesting and relevant 'instance' appears (more on this concept later), the therapist will make a note of it and go to visit it later, rather than diverting immediately to see it now and losing the thread of the preferred future conversation. Therapist and client can move from room to room together, backtracking if necessary. The key distinction here is making the most of each 'room' or phase, rather than leaping between rooms (a tendency I observe in many absolute beginners to SFBT, who seem to want to apply the all the questions at once!).

This development was presaged by the work of Jackson and McKergow (2002, 2007) on 'solutions tools'. These too were an attempt to find a larger unit of conversation than the question/answer, to

help learner practitioners and coaches keep track. Jackson and McKergow attempted to give snappy names to these tools, such as Future Perfect (preferred future) and Counters (including instances and also relevant resources) (Figure 2).

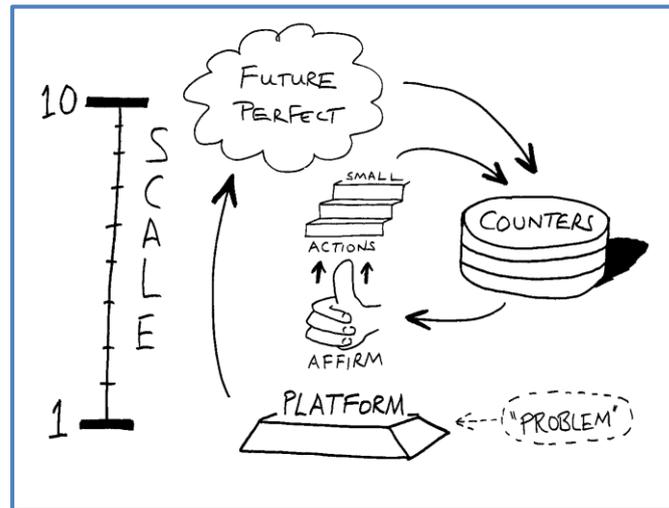


Figure 2

Solutions Tools (from Jackson and McKergow, 2002)

These terms don't always translate well into other languages, but they have proved durable over the past decade and more in helping practitioners to make the most of the conversation they are having (by sticking with it) rather than rushing off to other conversations when a tempting morsel is dangled by the client. There is also the advantage that the tools concept does not impose a 'correct order' for the tools to be utilised, giving flexibility to the practitioner within an easy-to-carry framework.

From goals to best hopes/common project

There has long been discussion as to the nature of goals in SFBT. In the early days, it seems to me that there was a focus on (small specific behavioural) goals as a way of helping the general move away from psychological hypothesising and towards some kind of discussion about what was desired by the client. The idea of 'goal oriented' was a useful marker to distinguish from other 'insight oriented' or 'deep' practices. However, the emergent nature of SFBT means that the process will conclude not when the client's goals are necessarily met, but when the client is satisfied that they can carry on their lives under their own steam – whether that connects with their initial goals or not.

The move towards starting with asking about the client's 'best hopes', as BRIEF and others do, is a step away from goals. A goal is a specific thing to be accomplished (possibly by a specific date). A hope is something in the future, something desired and yet not present (entirely) at the moment. A best hope is that, but more ambitious and perhaps even scarcely possible. (This is distinguished right away from the 'reasons for coming to therapy, which are usually in the past and not desired by anyone.)

The answers to best hopes, and such answers may not come immediately, are a way to define the theme or nature of the work. Harry Korman (Korman, 2004) has written about defining a 'common project' – common between the client and therapist – upon which they both agree to work for a while. Others including Michael Hjerth (in Klingenstierna, 2001) and Jackson & McKergow (2002) have described this stage as a 'platform', a place to stand when the work begins. It's good to remember the initial peroration that Steve de Shazer used in his later years: "There are no guarantees, but I will do my best, and I hope you will too. (Looking at client to get some kind of affirmative response)." This is offering a clear contract – I will work on your hopes together with you, and it will take both of us working together.

This is not goal setting. It's a title or theme for the work, one which can be put into practice right away in asking a miracle question or a scale to embark on the next phase of the interview. This leaves everything open to change and to evolution as things go on. If goals are set and then clung to, even small goals can put you in gaol (jail) with unexpected developments meaning that what was initially a reasonable goal now turns either into an easy stroll or an impossible dream.

Preferred futures and scales – same questions, different aims

The discussion of 'preferred future' (the day after the miracle, which usually happens tonight) and scaling questions have long been, and continue to be, central elements of SF practice. However, with the move from gathering information to design interventions to building rich and detailed descriptions, the aims of these processes also change. So, the therapist has a 'slightly different head on' when they lead into these discussions.

Rather than listening for behavioural patterns which might be amplified and repeated, the practitioner is more concerned with helping the client to develop and enrich their descriptions, particularly in interactional terms. Who will be doing what, in response to whom, with which tiny noticeable signs? Note how close this appears to the original MRI detailed language idea, but with a different aim. The purpose is not unlocking the whole case with an 'aha' moment, much more a gradual building of detail which somehow leaves the client in a different place at the end – even if there is no particular wizz-bang 'aha' moment involved.

From exceptions to instances – clearer focus on discussions about the past and present

Perhaps THE key element in the beginning of SFBT was the art of finding and constructing exceptions – times when the problem should have happened but didn't, or happened less. Indeed, back in 1988 when Clues was published this was the main strategy for the therapist – the miracle question and hypothetical futures only being discussed if no exceptions could be found. The idea was that the presence of these exceptions showed that not only was the occurrence of the problem not inevitable (as it often appeared to the client) but also that the client could, by clever action and observation, start to produce these exceptions deliberately. This opened the door to control and then reduction of the problematic behaviours, with the client in the driving seat.

The original idea of an exception finding – times when the problem doesn't happen or happens less - includes everything apart from the problem happening at its worst. This is a very broad category! These days it is much more usual for the therapist to embark on some kind of preferred future conversation first, which allows for a different and better defined alternative – 'instances' of this preferred future happening in full or in part, or past events which seem to prefigure this hoped-for future. This gives a much clearer focus on events which relate not simply to the absence or reduction of the problem, but connect to the best hopes and preferred future described by the client. This is a more focused inquiry, and may therefore bring more immediately useful and relevant ideas into the conversation. Others might refer to these various elements as 'pieces of better' (as distinct from just 'pieces of different') – and of course to discuss that, we need some understanding of what 'better' means in the context.

One way to start such a conversation is with the classic 'scale from 1-10' question, where 10 is the preferred future or best hopes realised (there is no need for a full miracle question in order to simply evoke the clients stated best hopes). The client thinks for a moment and then may say '3' or whatever. Of course, the next piece of conversation is 'how come you are 3 on the scale and not lower?' – again a classic piece of SF work which sits broadly unchanged, apart from the new focus on building rich descriptions rather than trying to deliberately prompt the client to action .

Losing hangovers from family therapy

MRI model brief therapy emerged from the same MRI team who had developed family therapy some years before (in the 1950s and 1960s). That group had become accustomed to using the trapping and paraphernalia of family therapy – a special therapy room equipped with a one-way mirror, a team of therapists sitting behind the mirror (unseen by the client), a telephone to communicate with the therapist in the room with the client. The family therapy routine was for the lead therapist to carry out the session with the client (perhaps being prompted by colleagues to ask certain questions) and then leave the client alone while they retreated to the team room behind the mirror. There, a conference would ensue about who had noticed what, what kind of intervention might be appropriate, and how it might be 'sold' to the client as being useful. The therapist would then return to the client and give an end-of-session message, including the intervention.

The idea of giving compliments to the client first emerged as a strategic move in these end-of-session messages. Someone observed that offering the client compliments about them, their handling of the situation so far, their useful strengths and qualities, produced a 'yes-set' – the client nodded along in agreement with these helpful points, and so was more inclined to accept the therapists' intervention.

If we continue to explore the new role of the therapist as being the elicitor of detailed descriptions rather than the designer of interventions, then some key things follow:

1. There is no need for a team any more. The conversation is for the client to hear, and the single therapist is part of that. The idea of others watching, hidden from view, seems not only costly but also rather creepy.
2. There is therefore no need for a break, as there is no intervention to design and nobody with whom to consult. In the original 1997 EBTA research definition, the break was one of six

elements which would indicate that therapy was properly 'solution-focused'. Times have changed.

3. There is not the same need for compliments in a sustained barrage, as the prelude to selling some kind of intervention. That is not to say that compliments are forbidden – more that the purpose of them changes into potential reframing of difficulties and normalising of challenges, and can be used at any time during the session.
4. And of course there is no intervention. Some (including BRIEF) would even say that any conversation about possible actions and next steps is unnecessary – the client will do something if they see fit, and if they don't see fit then there is no point asking about it. I personally, working in an organisational context, might still ask the client about their thinking on possible next small steps – the idea being that it's very normal to agree actions in these contexts, to the extent that some people assume that if they haven't agreed an action then they positively don't have to do anything, which is not the impression I seek at all. The focus is usually on helping them focus on *small* actions, much more likely to get done than large actions and so more likely to make a difference. Whatever, this is now at most a light touch final question to the clients rather than a complex intervention with coin tossing, pretending, formula first session tasks, or acting differently on alternate days of the week, and all the other aspects that featured in the strategic family therapy playbook.

Ending the session – no tasks or actions, more appreciative summarising

We have just seen that the end of the session has lost many of the trappings which used to be taken as read in the early days. There is no ritual of break, compliments, tasks. However, we have to bring things to a close in some way. Appreciative summarising by the practitioner can usefully be done here – it shows you've been listening, and offers the client the chance to hear some of the things they've been saying again, perhaps in a different order. One way to add an extra piece of detail which may help the client to look at smaller (and hence more do-able) details is to engage in a description of tiny signs that (N+1) has been reached.

Another way to engage in a kind of discussion about actions without talking about actions is to scale the client's confidence. Evan George (George, 2017) has recently written about three ways to use confidence scales at the end of a session:

- Confidence of being able to make progress on your best hopes (scale of 1-10, followed by discussion of what is helping to be that high). This can be particularly useful at the end of a first session.
- Confidence of maintaining the changes you have made (scale of 1-10, again followed by discussion about what helps things to be that high, and perhaps even higher). This can be useful then therapy is coming to an end.
- Confidence of maintaining change and of reaching 'good enough'. This concept of 'good enough' can be a useful way to gauge progress, in terms not of reaching a 10 but rather in the client's own experience at the moment.

One other aspects of ending sessions in SFBT 2.0 is an even clearer commitment to offering power to the client, in terms of whether there might be another session and when might be a good time for it.

So we might expect to see less of ‘please make an appointment for next Tuesday’, and more of ‘I hope that’s been useful for you... would you like to come back to continue our work together?’. Steve de Shazer always said that therapy should take as many sessions as it takes and not one more, so we should be looking to help the client decide if and when they wish to return. And if they think that’s enough, then it’s cause for gentle celebration.

Conclusion

In conclusion, we might summarise the similarities and differences between SFBT 1.0 and SFBT 2.0 as follows:

Summary table

SFBT 1.0	SFBT 2.0
<i>Remaining the same</i>	
Focus on what the client wants	Focus on what the client wants
Radical acceptance of what the client says	Radical acceptance of what the client says
Miracle questions and scales	Miracle questions and scales
Specific concrete details observable descriptions	Specific concrete details observable descriptions
Coping questions (if appropriate/necessary)	Coping questions (if appropriate/necessary)
‘What’s better?’ follow up	‘What’s better?’ follow up
<i>Looking different</i>	
Focus on questions	Focus on chunks of conversation, ‘rooms’, ‘tools’
Questions to produce information for tasks	Questions to develop client’s descriptions
Problem-free talk	Straight into ‘best hopes’
Goals (preferably small)	Best hopes, differences the best hopes will make to all concerned
Exceptions (to the problem)	Instances (of things connected with the best hopes/preferred future)
Compliments at the end of the session	Appreciative summarising through the session, no compliment barrage at the end
Break and end-of-session message	Offering chance of next session if needed/wished

It seems to me that while these two columns have a lot in common, both explicitly and implicitly, there are enough substantial differences to warrant a distinction being made. In particular the role of the practitioner is quite different, going from someone who might see themselves as a skilful task master to one whose role is to help the client expand their descriptions of what is wanted. In the former outlook the change will happen after the session, when the client goes out and does something differently (or views something differently). In the latter outlook, important change is happening right there in the session, in the conversation.

This is not to say that SFBT 1.0 is wrong, or bad, or outdated, or anything like that. There are people doing it right now, and having good results with their clients. However, if we are to progress SFBT it would seem to be clear about what we’re doing and not doing. I suspect that many practitioners are probably doing some from each column right now. The current situation, where all the above

happens under the same heading, does not seem to me to be a helpful place for practitioners, learners or indeed researchers. There is some initial research (Shennan and Iveson, 2011) that what I term SFBT 2.0 is more brief – and hence better, by the aesthetics of brief therapy – than the more established version. There is also experience – by me over several years and by others – that this newer version of SFBT is effective, efficient, and even more elegant than the previous versions. This of course must be tested. But it will be impossible to test if we don't make a distinction at the start.

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