International Journal of Solution-Focused Practices
2014, Vol. 2, No. 2, 40-51
DOI: 10.14335/ijsfp.v2i2.21
ISSN 2001-5453 (Print) ISSN 2001-6980 (Online)

The Situations Focused Model: A Map of Solution-Focused Brief Therapy used as an Open Systems Approach With Clients and in Human Services

Tomasz Switek
The Solutions Focused Approach Center

Abstract

In this article, I describe the *situations focused model,* an open systems model that aims to help the practitioner to position solution-focused brief therapy (SFBT) in the context of other sources of useful professional knowledge and to be most useful in face of the complexity of clients' needs in human services. The model facilitates the utilization of all potential resources and perspectives available in every situation. The situations focused model proposes a perspective of "both/and" instead of "either/or" in some key areas of solution-focused thinking. This article also addresses a tendency in parts of the SFBT writings, teachings, and practice to think in three types of dichotomies: 1) the SFBT approach versus other therapeutic approaches and bases of knowledge, 2) solutions versus problems, and 3) the client's expertise versus practitioner's expertise. This article proposes that treating these dichotomies as real areas of conflict are in many situations not useful, may be harmful to the field of SFBT, and may jeopardize the quality of treatment for individual clients. The situations focused model suggests a "both/and" approach to SFBT and other models of help, to solutions and problems, and to the client's expertise and therapist's expertise. The situations focused model suggests that these perceived dichotomies could be easily harmonized and provide a map to effectively utilize the solution-focused model in larger human services systems, and with clients who would potentially chose a type of treatment other than SFBT. The main implications and benefits of complementing SFBT with the situations focused map are discussed on theoretical and practical levels. The term "data situation" is introduced as a concept complementing and broadening the term "exception" in SFBT; *data situation* refers to potential sources of recourse from any part of the total helping context.

Keywords: situations focused, solution-focused, data situations, brief therapy, open system

This article will describe the *situations focused model*, a model or mind-map that aims to outline a way of positioning solution-focused brief therapy (SFBT) as part of the larger system(s) of professional competencies and resources available within the human services. The situations focused model represents an effort to clarify and adapt the ideas of SFBT for my Polish colleagues and for practitioners around the world who find it useful in their practice. *Both/and* is a type of logic well known for the solution-focused practitioner; it allows for greater variety, greater creativity, and an expanded scope of outcomes than a rigid either/or process of thought. It is therefore often useful when comparing two or more possible tracks in a real world setting. In this article, I propose to use this same logic in thinking of the solution-focused model in its context. An *open system* is defined as a system that

> continuously interacts with its environment or surroundings. The interaction can take the form of information, energy, or material transfers into or out of the system boundary, depending on the discipline which defines the concept. An open system is contrasted with the concept of an isolated system which exchanges neither energy, matter, nor information with its environment" ("Open System," n.d., para. 1). . . . In the social sciences an open system is a process that exchanges material, energy, people, capital and information with its environment. French/Greek philosopher Kostas Axelos argued that seeing the "world system" as inherently open (though unified) would solve many of the problems in the social sciences, including that of praxis (the relation of knowledge to practice), so that various social scientific disciplines would work together rather than create a monopoly whereby the world appears only sociological, political, historical, or psychological. Axelos argues that theorizing a closed system contributes to *making* it closed, and is

This article was published October 27, 2014.
Tomasz Switek , M.A. in social rehabilitation, Piastow, Warsaw, Poland
Please direct correspondence regarding this article to Tomasz Switek. E-mail: tomaszswitek@centrumpsr.eu

> thus a conservative approach. ("Open System," n.d., para. 5)

SFBT as an *open system* refers in this article to the willingness of the practitioner, in collaboration with the client, to use solution-focused ideas and techniques to consider the potential usefulness of a variety of knowledge bases and perspectives. The situations focused perspective suggests connecting SFBT to the broader context of human services and client everyday life, even when it does not strictly follow the client's current perspective. For this purpose, the situations focused model could serve as a guide.

A Solution-Focused Journey

The first time I heard about solution-focused therapy was 16 years ago when one of my mentors encouraged me to get more information about an interesting model that he was learning at Jacek Lelonkiewicz's Brief Therapy Center in Poland. At the time it was also becoming quite easy to find details about SFBT via the Internet, so my first Google result was "Hot Tips" and "Hot Tips II" by Insoo Kim Berg (n.d.-a, n.d.-b) at the Brief Family Therapy Center (BFTC). I was fascinated by the solution-focused perspective of conversations and the focus on working with the possibilities of all clients and began investigating the model further. A little later, I eagerly read more papers and books from solution-focused writers, such as *Keys to Solution in Brief Therapy* (de Shazer, 1985), *Clues: Investigating Solutions in Brief Therapy* (de Shazer, 1988), *Working With the Problem Drinker* (Berg & Miller, 1992), and *Residential Treatment: A Cooperative, Competency-Based Approach to Therapy and Program Design* (Durrant, 1993). I then met Luc Isebaert and learned the solution-focused model developed at the Korzybski Institute in Belgium, known as the Bruges model. After spending time in Bruges and reading Luc Isebaert and Marie-Christine's Cabié's book *Pour une Thérapie Brève. Le Libre Choix du Client Comme Éthique en Psychothérapie* [For a Brief Therapy. The Client's Free Choice as an Ethic Positioning in Psychotherapy] (Isebaert & Cabié, 1997), I was again very inspired and continued to develop my practice using all I had learned. Some of the basic ideas that were useful to me in the Bruges model (and that may not have been so prominent in the BFTC writings, even though used in the BFTC practice) were the concept of creating useful meanings (*eusemie*), the therapist's ability to create useful maps with clients (*hypothesis*), the utilizing and sharing of professional knowledge with the client, and understanding the solution-focused approach much more as a way of thinking than a matter of technique. Even though the basic solution-focused thinking stemmed from the work of BFTC in Milwaukee, there were actually a couple of hot spots around the world working and developing the solution-focused approach. With time, I attended many workshops at the Brief Therapy Center in Poland as well as many conferences arranged by the European Brief Therapy Association (EBTA). Listening to plenaries, partaking in workshops and informal meetings, and making friends with many solution-focused practitioners encouraged me to work on adapting solution-focused concepts to fit my own inner, personal ecosystem.[1] Giving obvious credit, I want to stress that both solution-focused traditions—from Bruges and from Milwaukee—in various ways make up the basis for my situations focused model. While I worked in ambulatory programs with substance users and people who experienced violence or engaged in violence against their families, I actively tried out and evaluated the ideas I learned.

In the following years, I worked with a wide range of clients and a wide range of situations—from marital crisis and parenting difficulties to mental health issues and coaching needs. I also taught, trained, and supervised other professionals. In parallel, I developed the ideas of a situations focus on the basis of years of accumulated practice and collegial discussion with those with whom I have had privilege to collaborate.

One of the main questions that further inspired my solution-focused thinking and practice came from Luc Isebaert during a visit to Bruges and the AZ Saint John Hospital Psychiatric Unit in 1997. As far as I remember, the question was: "Tomasz, do you really think that SFBT is about using specific technique as a must? That you have to use the miracle question in order to be sure that you work in a solution-focused way?" My answers to these and related questions were the beginning of the crystallization of the situations focused model, which I then developed over time as a result of discussions and observations within the teams in which I worked and supervised. At this time, I worked at an ambulatory setting for people with alcohol problems as well as a non-governmental organization aimed at preventing domestic violence. I worked for the social welfare system with a diverse range of clients with differing diagnoses. One very useful idea in these situations was that SFBT is not about eliminating patterns, behaviors, and thoughts, but rather about creating useful alternatives to them. So I, as many fellow solution-focused practitioners, drew the conclusion that it was in accordance with the solution-focused model to continue using some of my previous therapeutic knowledge and techniques—which I still found useful—as I was simultaneously establishing SFBT ideas as my professional backbone. Working with clients raised important questions to my team and me: Is it always useful to stay exclusively within the client's perceptions and perspectives? In SFBT, the idea is that a therapist should "leave no footprints."[2] During this time, it was very helpful to be able to constantly observe and consider the answers that de Shazer and Berg provided in discussions on the SFT-l listserv.[3] My impression from these discussions was that they were strongly devoted to start by

[1] With the term *personal ecosystem*, I refer to the system of all cognitive factors that exist in my psyche, brain, or wider body—such as knowledge, thoughts, meanings, concepts, and words—that strive for equilibrium.

[2] This is an often cited but little referenced citation to Insoo. In George, Iveson, and Ratner (1999), the source was said to be the SFT-1 list.

[3] *SFT-1* is an email listserv. See http://www.sikt.nu/enginstrsft.html for details.

reflecting on what the client wants. They, in fact, described their work as almost exclusively taking the client's perspective and using the client's perceptions, putting aside perspectives that could come from the therapist's professional knowledge base.

Another source of conversation on the solution-focused model was at the annual EBTA conference. These conferences were a great place to talk about these questions and consider different approaches to the current descriptions of the solution-focused practice and what may lie beyond it. In the beginning of my interest for the solution-focused model I felt I identified very much with it, feeling it was the right way. However, after the discussions I had with my colleagues and my experiences in practice, I changed my initial conviction about the solution-focused model from "the best and the only way of helping people" to a position that it is "one of many methods, as good and as weak as other methods, but closest to me." Thus, with this change in perspective, more questions emerged. I asked some of my solution-focused colleagues in order to obtain more answers and, though I had useful conversations, I found that there were questions that needed addressing about how to use the solution-focused model as effectively as possible and without risking to hold back any sources of help that might benefit the client or help ease his or her situation.

Basic Concerns in Need of Addressing

One concern that I have found very important both in practice and in teaching the SFBT model was how to position it in the larger context of therapeutic knowledge and models, methods of treatment, theoretical perspectives, and research. I have found that it is important to view SFBT in the context of already existing approaches that are defined by and gain their identity through descriptions of their theoretical and practical specifics. To use the solution-focused model in a professional context, it was important to position it as a model that included a respectful stance toward colleagues that use other models of therapeutic work. In solution-focused writings, this open stance can be found, for example, in the *Solution-Focused Therapy Treatment Manual for Working With Individuals* (Version 2), published by the Solution-Focused Brief Therapy Association (SFBTA, 2013):

> SFBT is most similar to competency-based, resiliency-oriented models, such as some of the components of motivational enhancement interviewing (Miller & Rollnick, 2002; Miller, Zweben, DiClemente, & Rychtarik, 1994), the strengths perspective and positive psychology. There are also some similarities between SFBT and cognitive-behavioral therapy, although the latter model has the therapist assigning changes and tasks while SFBT therapists encourage clients to do more of their own previous exception behavior and/or test behaviors that are part of the client's description of their goal. SFBT's focus on behavior, description and social context also show similarities to third wave behavioral therapies but SFBT does not exclusively rely on the same theories and change techniques as a part of its change processes. SFBT also has some similarities to narrative therapy (e.g., Freedman & Combs, 1996) in that both take a non-pathology stance, are client-focused, and work to create new realities as part of the approach. SFBT is most dissimilar in terms of underlying philosophy and assumptions with any approach which requires "working through" or intensive focus on a problem to resolve it, or any approach which is primarily focused on the past rather than the present or future. (p. 9)

In this excerpt, the similarities and differences between the SFBT model and other models are described in a non-evaluative and comparative way. In contrast to these neutral descriptions, there is another very common way of positing the solution-focused model and it is more evaluative and seems to propose conflicts between SFBT and other bases of professional knowledge in its argumentation.

This way is, for example, presented in the first chapters of the most recognized solution-focused textbook, *Interviewing for Solutions* by De Jong and Berg (2013). This book provides an excellent starting point for anyone who would like to know about the solution-focused approach. It has many good qualities and is well-structured and clear in the descriptions of the solution-focused approach. But it also has a couple of initial pages that present the solution-focused model in a way that risks the reader interpreting SFBT as an exclusive and closed system of ideas. This way of positioning the SFBT model is not uncommon among solution-focused trainers and practitioners and thus, the text is representative of this way of thinking. The alternative perspective that this article presents—positioning SFBT model as a more open, flexible, and both/and-oriented set of idea—is also well represented in teaching, practice, and writing. It is widely used in human services where the solution-focused model has been implemented, but it has not yet been explicitly and clearly described as an alternative model or map in a logical and consistent mapping of ideas.

As the text in *Interviewing for Solutions* is so well known and presents SFBT as a more closed system of ideas so clearly, I have chosen it as the reference point to clarify and contrast the concerns that led me to formulate an open systems and "both/and" model for how to position solution-focused therapy: the situations focused model.

SFBT in Relation to Other Models of Therapy and Professional Knowledge

Unfortunately, one of the tendencies in solution-focused teaching is to comment in a generalized and negative way on other therapeutic models, which are then labeled *traditional*, *problem-focused*, or *problem-solving* (as opposed to *solution-building*), or are deemed to use the *medical model*. Such thinking implies that a "traditional," "problem-focused," or "medical" model would be bad or faulty by

definition. As if all the models which existed before the development of SFBT could be placed in one box and be summed up to more or less one unified point of reference. The basic textbook (De Jong & Berg, 2013) states,

> Despite their differences, however, the helping professions share some equally important commonalties. These commonalties, which derive from the medical model, together make up the basic features of a problem-solving paradigm. . . . Since the appearance of the medical model most helpers follow the same basic *structure* when providing assistance to clients. They work from the premise that, before the client can be helped, the practitioner must figure out what the client is suffering from or struggling with. This is true whether the practitioner thinks in terms of assessing problems or needs or diagnosing disorders. The heart of this premise is that a necessary connection exists between a problem and its solution. (p. 7)

The above description by De Jong and Berg (2013) places all the practices within "a problem-solving" paradigm as in contrast to the solution-focused approach. Then, they describe the characteristics of the use of the medical model in helping professions:

> The generic structure of problem solving—first determining the nature of the problem and then intervening—influences the content of the interaction between practitioners and clients. Practitioners characteristically ask clients to spend significant amounts of time describing (and sometimes analyzing) the who, what, when, where, and why of their problems to gain sufficient information for accurate assessment of the problem. In this process clients often fill out long intake forms about themselves, their families, their occupational histories and other aspects of their lives. They may be asked to list the problems they have been experiencing and complete assessment interventions such as personality tests and family-interaction questionnaires. . . . As a result, the interactions between clients and practitioners focus on problems. (De Jong & Berg, 2013, p. 8)

Clearly from this description, clients who meet professionals who are using a "medical" or "problem-focused" model will experience a lot of forms to fill out and questions about problems to answer. Many solution-focused practitioners may very well recognize some aspects of the above description from a less than helpful treatment context, where they felt helpless against the sort of dehumanizing system that is hinted in this description. Mental health or social service systems where clients fill out forms and go through the routines of the system, but then get very little actual help from these procedures do, in fact, exist. However, is the above description a fair account of how other models of therapy or treatment actually work? Is it an accurate description of the totality of the value of professional knowledge and research (or even of using forms at intake)? Or is it more a picture painted namely to convey a background against which the solution-focused model can be the shining light in the foreground, so as to make it easier to argue its benefits? Could there be a need to demonize other models of therapy and other systems of knowledge to make an argument for the solution-focused model? It could be a good idea at this point to ask if this way of teaching and positioning the solution-focused model actually works in favor of the model?

My experience from practice and teaching at our SFA Center in Poland is negative; it is not useful and instead, it has brought us many difficulties when we have tried to teach the solution-focused ideas using this position. These difficulties would not have been necessary if we would have had a neutral and balanced approach. In time, we turned toward describing differences and similarities more specifically, rather than taking the position that the solution-focused approach is always better. I thus take the position that the way in which we use and combine models of therapy needs to be made much more sensitive to the needs of both the agency and the individual client.

The Solution Versus Problems Dichotomy

The idea that *talking about problems* is always less useful than *talking about solutions*, manifests itself in the description of "problem-solving" as a paradigm. De Jong and Berg (2013) wrote, "We believe that problem solving has been the dominant paradigm of practice in the helping professions" (p. 6). They described the *problem solving paradigm* (as opposed to the *solution-focused*) as a homogenous collection of ways to treat problems stating that "the problems found and the names given to them are different but the structure of helping remains the same" (De Jong & Berg 2013, p. 7). Even though the authors provided a footnote to soften this statement, the main idea that was presented is that problem-solving is a way of working that works against clients' interests, and that the solution-building process of the solution-focused approach, on the other hand, is very different and better.

Further, in the section "Describing the Problem," De Jong and Berg (2013) wrote about the solution-focused practice:

> We ask for fewer details about the nature and severity of client problems, and we do not ask about possible causes of the problems. Instead we listen respectfully to clients' problem talk and think about ways to turn the conversation toward the next step, which initiates solution talk. (p. 17)

In practice, this dichotomy between problem-solving and solution-building seems very academic and unpractical, and it is often unclear in practice if a conversation is problem-solving or solutions-building. Additionally, there is lots of evidence from clients, practitioners, and research that points to the usefulness of many models that within the

solution-focused vocabulary would be called "problem-focused" or something similar. Maybe this idea is derived from a need or inclination within the solution-focused approach to establish a dichotomy between the concepts *problems* versus *solutions,* as though they are two separate and mutually exclusive patterns of conversation as exemplified by the use of concepts like "problem-free talk," "solution-talk," and "problem-talk."

The problem versus solution dichotomy has been created and described in more and more elaborate ways with a tendency to question the problem-focused way of working as a way to promote the solution-focused way of working. For example, Berg and Kelly (2000) described the "problem-solving paradigm, sometimes called 'positivistic' or the 'scientific approach'" or the "medical model" as the practitioners "begins with a detailed assessment of the problem" (p. 14-15), and later they described child protective services risk assessment tools as where the client is told what is wrong and what the professional thinks should be done to fix it (p.15). They also noted that these models reinforce an imbalance of power: The professional's attitude in the conversation is, "If you don't do what I think you should, you may lose your children." (Berg & Kelly, 2000, p. 15). When they present this description there are not any acknowledgement of the issues of power imbalance between parents and children or the actions undertaken by the parents earlier leading up to child protective services being involved with the family. Additionally, in writing about what they called a new paradigm, they described the power arrangement of solution-focused work differently: "When we work with the client's own ideas and successes, it is easy to see that the concerns for resistance will diminish and the client can easily own up to the successes" (Berg & Kelly, 2000, p.18). Problems are often described within the solution-focused model as one category of the client's reality, and solutions as a very different and better one (George et al., 1999). It is not hard to get the impression when reading this and other basic solution-focused literature that part of the identity of the solution-focused approach has been created by relating to and negating models that are collectively described as having a "problem focus" (Sharry, Madden, & Darmody, 2001). Sharry et al. (2001) stated, "Case discussions with colleagues became centered on elaborate 'exposés' of clients' problems, the more problems we found and the more interwoven and intergenerational they were the better" (p. 14). Although such descriptions refer to the authors' strong personal experience, in the context of a textbook, they can be easily mistaken for a neutral description of a model itself and its misuse can be made to represent the model. Further in the text, the authors conclude: "It strikes us that a well-timed, genuine framing of person's strengths can do more good that a well-timed, genuine framing of their problems and weaknesses" (Sharry et al., 2001, p. 15).

The above are just a few examples and it is quite easy to find more of this rhetoric to position the solution-focused model as superior at the expense of other models, which are misrepresented and then described as inferior. I also want to stress that the books quoted above were all very important for me in learning the solution-focused model. Thus, apart from the positioning of the solution-focused model, I would recommend them for anyone wanting to learn the model.

While there is an obvious difference between a focus on psychopathology and one on health, it seems to be a trap to present misuses of a focus on psychopathology as a preface to presenting positive applications of a health focus.

The very concept of "problems" could be seen as created *within* SFBT. Many of the basic solution-focused techniques described have the therapist asking a question about the client's life without "the problem." For example, in the *miracle question technique*, the therapist engages the client in a conversation about how life would look if a miracle were to occur such that all his or her problems were suddenly resolved.[4] Also, note the technique of *problem-free talk* as a way to find effective ways to locate clients' resources. *Exception (to the problem) questions* help clients focus on the times where the problem is not present or is less intense so as to develop a *non-problem* narration. In many ways, the practitioner is encouraged to look for something different to the problem, to look for what seems to be better or more useful. Also, in the promoted solution-focused techniques like the miracle question, the technique is described in opposition to the problem. Considering that it is an approach that focuses on solutions, it seems that the SFBT techniques actually focus a lot on what the SFBT terminology calls problems. Actually, it is within the SFBT model that the problem is actually reified into a real factor, with the purpose of serving as a reference point in the building of another factor that also is considered real: the solution.

A phrase often attributed to Steve de Shazer is that "problem talk creates problems, solution talk creates solutions." [5] However, many ways of talking about something that, from a solution-focused perspective would be called a problem in a "non-solution-focused" way, have a good chance of being helpful to a client under the right circumstances. Michael Hjerth attempted to nuance this statement by saying that "talking about solutions creates more talk about solutions, but not necessarily more solutions, and that talking about problems, creates more talk about problems, not obviously more problems" (M. Hjerth, personal communication, October 19, 2014). Also, recognizing that the problems–solutions dichotomy is a false (or not useful) dichotomy makes it possible to consider the idea that talking about so-called problems (asking details about problems, how it developed and so on) or so-called solutions (asking about exceptions and details of them) may be equally efficient in a supporting processes toward wanted changes. The most important difference would be in the way

[4] de Shazer's (1988) miracle question: "Suppose that one night, while you are asleep, there is a miracle and the problem that brought you here is solved. However, because you are asleep you don't know that the miracle has already happened. When you wake up in the morning, what will be different that will tell you that the miracle has taken place? What else?" (p. 5).

[5] Even though this citation is often attributed to Steve de Shazer, in our search, we were unable find the original source. It is possible that it is not an accurate quotation. Even so, it is a commonly used and popular aphorism that sums up much of the stance of a problem/solution dichotomy that has gained popularity with increased interest in the solution-focused model.

in which it is done—how the conversation is created between client and therapist. This brings about the next dichotomy that often is described in solution-focused writing and teaching: the dichotomy between the client's and the therapist's expertise.

Client's Versus Therapist's Expertise

Another dichotomy that often appears in the teaching and practice of the solution-focused model occurs when the therapist's professional knowledge and experience is contrasted to that of the client, as if the use of one would lessen the importance of the other.

Solution-focused and not-knowing. In my reading of *Interviewing for Solutions* (De Jong & Berg 2013), it seems that the authors define the term *not-knowing* (Anderson & Goolishian, 1992) in a more narrow way than intended by its originators. De Jong and Berg (2013) stated, "If, as a practitioner, you wish to put clients into the position of being the experts about their own lives, you will have to know how to set aside your own frame of reference as much as possible" (p. 20), while Anderson and Goolishian (1992) described the stance of not-knowing as the therapist being "in a state of 'being informed' by the client," also noting that the therapist should "set aside any preconceived opinions and expectations" (p. 29). Thus, De Jong and Berg seem to make a more radical conclusion that differs somewhat from Anderson and Goolishian's stance of the not-knowing therapist "being informed" by the client, toward proposing that practitioners should "set a side your own frame of reference as much as possible" (De Jong & Berg, 2013, p. 20). The aim may be to make sure to include the client's perspective, but it also risks negating the therapist's professional knowledge, for example, by equating the therapist's professional knowledge and expertise with any presupposed "frame of reference." In my reading of this introductory part of De Jong and Berg, it seems that the professional therapist, psychologist, or social worker is advised to not use their own frame of reference, which includes their professional knowledge base.

In this way, another dichotomy is at risk of being created: that between the client's and the therapist's expertise. Instead of proposing the client's perspective as the primary point of reference for the therapist, the client's perspective effectively replaces the therapist's professional knowledge as if there is a necessary conflict between being a skilled professional and listening to the client. In its extreme form, this logic collapses: What if the client's perspective includes using the professional's knowledge base? Or what if the client's frame of reference was cut short for some reason and he or she does not know how to ask for the help that he/she would want if he/she knew about it? For example, what if there is a professional knowledge base that the client would want to access if he or she were informed and could make an informed choice? Such perspectives are at risk for being made invisible. A last, perhaps more humorous, consequence of this logic is, of course, that the solution-focused model itself is located within the (professional) frame of reference which the therapist is advised to set aside.

But back to a more serious note: There are also risks of the practitioner relying on and utilizing the client's resources beyond what will be supported by the context outside the therapeutic relationship, and this may actually disempower the client and limit his or her possibilities. Thus, following a humanistic tradition, the therapist might consider gathering and combining different perspectives, knowledge, and experiences while still respecting the client's choices and working within his or her worldview.

Also others' perceptions (not only the client's or the therapist's), may be important in a solution-building the process. The art of solution-focused work would then lie in the process of effectively connecting and utilizing the potentials of a situation and there would be no need to label some methods or bases of knowledge as "problem-focused" or any body of knowledge to be neglected a priori. The point of this argument is that the client has a realm of expertise and is the owner of his or her life, but the client is not an all-knowing expert who possesses every idea or answer in existence. Thus, incorporating external perspectives can be more effective than constantly working within the client's current perspectives.

In clinical practice, it is difficult to support the idea that the balanced and client-oriented use of diagnoses, the considering of deficits, the sharing of one's professional understanding about a problem with clients, and the creating of hypotheses about the situation should not be treated as an option within SFBT. The question should instead be *how* this is done in a client-oriented and collaborative way and from a solution-focused point of view in a context of adapting to the client's preferences.

This is important because most solution-focused professionals are responsible for much more than asking questions. These responsibilities may, for example, stem from one's role in an organization—the solution-focused practice will lead to different performances depending on one's profession, such as social worker, therapist, psychologist, psychiatrist, or school teacher.

Also, depending on the client's characteristics such as age, condition, and context, using and applying SFBT methods should be carefully adapted to the his or her needs. There is a huge difference between working, for example, with children versus adults, or physically well versus physically disabled clients. So, before deciding that, for example, a DSM diagnosis, an assessment form, or an intervention is not solution-focused, there is a need to look at the context and how it is used. In many situations there are options available for which there is no way of knowing in advance if they are useful to a client or not. Many so-called problem-focused interventions and models might prove to be a good match for a client. It is always the professional duty of the practitioner to carefully figure out what might be useful in collaboration with the client.

The Risk of Narrowing Client's Opportunities for Help

If the above described dichotomies between problem versus solution and client's expertise versus therapist's expertise become too dominant in the solution-focused practice, there is a risk that practitioners using the solution-

focused model limit themselves from the developing knowledge within their professional field (e.g., medicine, psychology, or social work) and get caught up in a self-confirming loop, where ways of working labeled "problem-focused" are dismissed a priori and new knowledge and ideas have no or little access. The practitioner may think that he or she is acting in the client's best interests or in line with the client's perspective, but the risk is that he or she is not.

Please note that this questioning of some aspects of the solution-focused model is directed at how it sometimes is described and taught as a model with one absolute exclusive perspective, and how this stance risks acting against the client's interests. These concerns led me toward the formulation of what would become the situations focused model, an open and inclusive model positing SFBT as an open systems model. The model offers an alternative map for the practitioner who also sees potential value in the professional knowledge base and other perspectives, but still wants to work within a solution-focused frame of reference.

Is There a Possibility for an Open and Inclusive "Both/And" SFBT Perspective?

In clinical practice, many solution-focused practitioners actually keep, combine, or use other models of therapy in parallel with solution-focused practice. They also often do not give up the use of professional expertise or knowledge, but rather include it in their practice when their clinical experience gives them reason to do so. Not doing this would, in many situations, be regarded as unethical because it would limit the possibility of providing the best possible helping service to the client. This perspective, however, risks being obscured in teaching that is based on the dichotomies portrayed above. In an attempt to portray the unique benefits of the solution-focused model, the authors, maybe unwillingly, create and uphold a conflicting stance between solution-focused practice and the rest of the available bases of professional knowledge in the helping professions.

Development of the Situations Focused Model in Practice and in Teaching

As described above, the idea of a situations focus came out of the clinical work in our team, our supervisions and training all over Poland, and out of discussions with colleagues in different contexts. One important part of the development was from my presentations at international conferences. In this context, I found that the idea of working from a both/and perspective regarding professional knowledge and clients' expertise was often used and, also, that many colleagues recognized the need to find alternatives to the problem versus solution distinction. The first versions of the model were presented at the EBTA conferences in Krakow, Poland in 2006 and Bruges, Belgium in 2007. Substantially more refined ideas were then presented later during the EBTA conference in Torun, Poland in 2012 and Bern, Switzerland in 2013. In 2014, it was presented at the EBTA conference in Leeuwarden, Holland, and a presentation of it has been accepted for the SFBTA conference in Santa Fe, New Mexico, USA, in November 2014. Some of the basic elements of this model were also described in the book I published in Polish under the title *Sciezki Rozwiazan* [Solutions Paths] (Switek, 2009).

Many times when meeting clients, it was an experience of the complexities of change, in some cases, the so-called *problems* was experienced as a situation that was the source of many negatives, and at the same time, of some positives. In a similar way, solutions were experienced as a situation of many positives and with some negatives. Clients that had achieved the so-called solutions sometimes found the outcomes no longer wanted, mainly because of the costs that were connected with maintaining them. I did not see problems and solutions; what I saw were situations that came and went and my trying to be of help in the best way I could.

I also saw that defining something as a problem or a solution was very tricky and that, in fact, probably most everything could be called both a problem and a solution, depending on one's perspective, values, and points of reference. This helped me to realize that keeping the distinction between problems versus solutions was not as useful an idea as I would have liked it to be; it had led me to experiencing many phenomena as full of negatives, when I could have seen positives. One of the negatives was that the dichotomy made it difficult to find useful, solution-focused conversation around parts of situations that were connected to what was called a *problem focus* and its focus on the roots, understanding, dynamics, and attributes of a problem. On the other hand, it was also difficult to talk about potential negatives with conversations about preferred future situations, as they were defined as solutions.

A practical conclusion, still based on using the labels of problem and solution, was that solution talk could be a talk about solutions, as well as about problems, and that problem talk could be a talk about problems, as well as about solutions. This understanding that neither problem talk nor solution talk relies so much on the theme of conversation (i.e., a diagnosis, a list of strengths, a list of problems, or an assessment could each be parts of problem talk or solution talk); rather, the key is in the way to talk about clients' life situations. The importance was the shifting from *what* I talk about to the *how* I talk about it; I could then talk about all situations, their content, meanings, and positives and negatives. Given this shift, one specific article on the dangers of solution-focused therapy becoming solution-*forced* brief therapy (Nylund & Corsiglia, 1994) seems still valid. Nylund and Corsiglia (1994) described how a compulsive need for the therapist to use words like "change," "better," "good," "preferred future," "not-knowing," and "doing less" in replacement of any problem-based narrations may, in fact, be less useful or even harmful to the client's therapeutic experience.

The Concepts of the Situations Focused Model

The main idea of the situations focused model is to leave behind the labeling of situations or conversations as either being a problem or a solution. The idea is to then leave the problem versus solution dichotomy and to move toward using the more neutral term *situation(s)*.

The situations focused model defines the term *situation* as the status of the circumstances, factors, or the combination of circumstances at a specific point (present) or nonspecific point (preferred or data) in time that contains components and their understandings. In other words, a situation is the way in which something is positioned and connected with its surroundings. This definition of "situation" is based on that in the *American Heritage Dictionary* ("Situation," n.d.). The neutrality of description also demonstrates the attempt to consider all aspects as possibly containing positives and negatives, and advantages and disadvantages.

In my work, I do not use the problems–solutions dichotomy anymore; instead, I use the concept of situations, which seems to be much more neutral (i.e., it allows for consideration of all so-called positives and negatives with a variety of possible meanings and validations) and thereby optimal as an alternative to talking about solutions and problems. From my perspective, the word *situation* is more amenable to questions such as: What was it? What is it? What will it be? I found that it is important for a therapist to be able to pose these questions in a non-evaluative way, to allow multiple aspects of the so-called positives and negatives of a situation to be included in the therapeutic conversation, and to be free from the risk of compulsively changing the client's perspectives to fit a solution-focused perspective.

Considering things from different perspectives and contexts showed very well that the same "something" can be useful and not useful at the same time; that is, it can be useful in one context of life (e.g., family), but not in another (e.g., work). Then, it is much easier to grasp that the figure (its positives and negatives) depends on the selected background. Defining something (e.g., a diagnosis, an assessment, a therapeutic intervention, a self-help group, or a perspective that may lie outside both the client's and the therapist's current perspective) as problem-focused or as solution-building may then be considered in a more flexible way depending on the context, and the meaning of the situation can simultaneously contain positives and negatives. I do think that this stance is also present as a possibility in the current description of the solution-focused model, but I propose that it has not been defined and described as such, and it is in this context that I hope the situations focused model can provide a mind-map for practitioners to navigate.

The Use of Neutral, Non-Evaluative Descriptions

The concept of situations makes it possible to formulate more neutral descriptions and to use evaluative descriptions more sparsely and when helpful. This makes it possible to start using the terms *problems* and *solutions* in a complementary way—as possible options to describe the same things, since the same situation can be perceived as a problem and solution at the same time. In my current practice, I think in terms of positives (pluses) and negatives (minuses) more than I think in terms of problems and solutions. I also use the term *preferred situation* instead of *preferred future* because a preferred situation seems much more within reach than a preferred future, which seems further away in the more distant idea of the future. Using the concept of preferred situation also serves to widen the concept from exclusively framing change as in direct connection with time, as when focusing on the preferred future and places change somewhere beyond the line of time. Thus, it can be somewhere in time, even almost now.

In a conversation, all situations can be described in a neutral way by asking questions such as:

- How is it? What is going on? How do you react? What is going on in your mind?
- Tell me more about your (past, present, preferred life situation . . .)
- How would your partner describe the situation?
- What's going on around you?
- I would like to hear more about the relationship with . . .
- What do you think about . . . ?
- Can you say something about yourself and your work?
- As a therapist, this is how I see the situation you describe. . .

Additionally, all situations can be described using evaluative questions when defining some of the minuses or pluses. The questions below are constructed to talk about a present situation. I do not propose that one way of asking is more solution-focused than the other. I also do not consider one to be problem-focused and the other solution-focused:

- What worries/makes you somewhat happy in your situation?
- What is difficult/okay for you regarding your children's reactions?
- Tell me more about the troubles/advantages you're facing in this situation?
- What is hard/easy to accept about your workplace?
- Which of your reactions are not useful to you/your family?
- What don't/do they like about your attitude?
- Please describe your deficits/resources as a . . . a bit more.

Some of these may seem like good constructive questions, while others may not seem so useful. It depends on the context in which you as a reader perceive how they would be used; the point is that the value of the evaluative questions cannot be decided out of context.

Three Perspectives: Present, Preferred, and Data Situations

In the present situation, there are three main perspectives to consider while having a preferred situation-building conversation: neutral descriptions, negative descriptions

(minuses), and positive descriptions (pluses) of the present, past, and future. Thus, the three perspectives are the present situations, the preferred situations, and the data situations.

Notice that in this model these three types of situations all have a different type of quality. *Present situations* are defined by the perspective of time—the most important factor of the present situation is its presence. The present situation is about something that simply exists now in the client's life, or at least, something the client thinks exists. There is a strong connection between the present situation and the client's experiencing and understanding of it. When moving toward the concept of *preferred situations,* the quality of time is not in the foreground—a preferred situation is not located directly in the time perspective. It is not in the future; rather, it is only located somewhere in time—it may be in the future, but it could also be in the present or not related to a place in time. By losing the ties to time, it becomes more a matter of a "possible now" than just a "possible future" as a linear course of understanding would suggest. Instead of using time as the quality, a perspective of a will quality—a quality of something more wanted, more desired, more preferred—is used. Again, we do not use the concept of preferred *future* since this wording points the perspective somewhere in the future. The point is to bring the ideas of change closer to the client's experience, and the hope is that the concept of preferred situation is closer to the client's now than a preferred future.

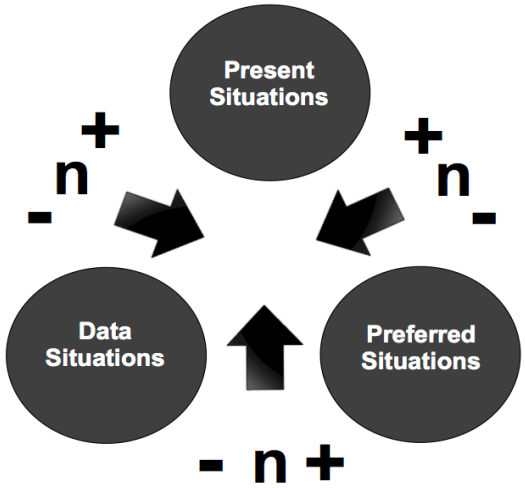

Figure 1. Situations focused perspectives.

Also, because moving toward the past and utilizing past experiences requires a concept that includes more types of situations than the concept of exceptions, I decided to introduce the concept of data situations. In SFBT, the tradition of utilizing the client's past experiences is called exceptions. This refers to times when the problem did not appear or was less intense, or when at least parts of the client's goals or preferred situation already existed. The exception technique always refers to the client's personal experience. Berg and De Jong (2002) defined *exceptions* as "those past experiences in a client's life when the problem may reasonably be expected to have occurred, but somehow did not" (p. 104). In the situations focused model, the idea is to broaden this concept and to try to utilize many sources of experience, including those that are external to the client's own personal experience. This broader concept has been developed over several years and tested in our trainings and in practice. In training, we first present the traditional definition of exceptions and after that, we present the broader definition of data situations, which include exceptions as well as the experiences of others. Up until the writing of this article, I had not had a term to separately define the concept, and so an important contribution in this article is the term data situations: *Data situations* are the client's or others' experiences that may be useful in order for the client to achieve preferred goals and preferred change.

The concept of data situations is described by the quality of the experience, knowledge, know-how, and information that they contain. It is based on the logic of the SFBT definition of exceptions. Data situations refer to past or almost present situations that contain useful knowledge, information, or data that can support the achievement of client's, others', or institutionally-established goals. An obvious source of data is utilized using the exceptions-finding technique when asking the client of his or her own exceptions based on his or her experience. But the situations focused model reaches beyond the client's experience and aims to explicitly utilize every possible source of experience—internal and external—to the client. See Figure 1 for a conceptual model of the three perspectives.

In situations focused conversations, all situations contain the possibility of a neutral description while also defining possible evaluative descriptions that are positives (pluses) and/or negatives (minuses). Before expanding on the concept of data situations, I will introduce three main social perspectives that, in the development of the situations focused model, proved to be important in utilizing the potentiality of recourses available to the clients in their total context.

Three Main Social Perspectives: Client's, Others', and Therapist's

In the situations focused model, there are three main social points of reference or perspectives (see Figure 2) from which to describe and build the descriptions of the present, preferred, and past situations. The first one seems to be very natural to the solution-focused model: the client's perspective. The second perspective is also often utilized with the wider solution-focused approach: the perspective of others such as family members, friends, and so on. Lastly, within the situations focused model, the therapist's professional perspective is also incorporated. To include a professional perspective and still work within the wider context of the solution-focused approach, the therapist needs, as always, to be incorporating solution-focused basic assumptions and ethics.

Below are some examples of questions that are formulated with these three social perspectives in mind; they can be modified as needed:

- What do you think about your present/future/past situation(s)?
- What do others (e.g., family, friends, and coworkers) think about your present/future/past situation(s)?
- Would you like to know something about what my experience as a [insert professional role] tells me about this present/future/past situation(s)?

In the situations focused model, the client's perspective is still the dominant one; at the same time, the perspectives of others and the therapist could also be potentially valuable to the client. These additional perspectives can invigorate working on and achieving preferred situations.

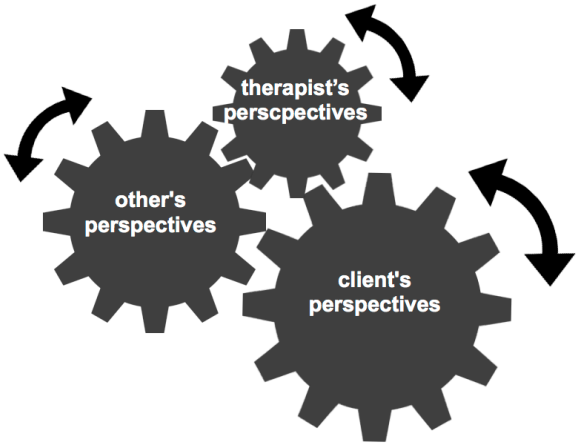

Figure 2. Three social perspectives that may offer useful resources, information, and ideas for the treatment.

This is achieved by describing the present situations, data situations, and preferred situations from these perspectives. Thus, for example, the miracle question technique is used not only to get descriptions of the client's perceptions or those of other people from the client's life, but can also be applied to elicit professionals' (i.e., the therapist's) descriptions of their perceptions about the client's desired change in cases where it seems to be useful or necessary. This means that sometimes the therapist asks the miracle question to himself/herself and gives detailed answers, which I have found very often to then be written down by clients. Then, the client and therapist talk about this miracle picture and consider some of the similarities and differences between the answers and think about some of the other aspects that emerge from the process. Another technique used is *situations focused scaling*, where the perspectives of the client, others, and also the therapist are potential perspectives to utilize. Answers on the scales and the numbers given provide a variety of perspectives, and the work of the therapist is then to make them work for the client in a useful way.

The Concept of Six Levels of Data Situations

Within the situations focused model, *data situations* are defined as follows: Any data from a situation, usually from the past, which potentially could be useful for a client in the context of the present situations and the preferred situations. Theoretically, each conversation about data situations (which includes exceptions) is undertaken to meet at least one of two types of goals. The first of goal is inspirational and the second is operational.

The definition of an *inspirational goal* is a goal achieved by talking about the exceptions/data situations and focusing on building pictures of the client's definition of his or her better functioning. The therapist's main interest is in the description of how the data situations were experienced rather than on finding out possible sources or means of achieving the state. In contrast, an *operating goal* is directly focused on the aspects of know-how such that the therapist helps the client figure out possible connections, positive influences, and useful strategies that allow the client to achieve the preferred situation.

There are different kinds of data situations in the model, and only some of them stem directly from the client's experience. But still, the therapist refers to the client's experience in searching for data situations, which is also the obvious and natural first choice in all solution-focused work.

Figure 3 visually represents the six levels of exception situations within the situations focused model. The client's perspective of what is and what is not a data situation (exception) is the starting point and in many cases, this gives sufficient information and material to provide the client with adequate help, staying within the ordinary solution-focused framework. There are also openings for the therapist to look for data situations from other sources and other perspectives not usually described explicitly in solution-focused literature.

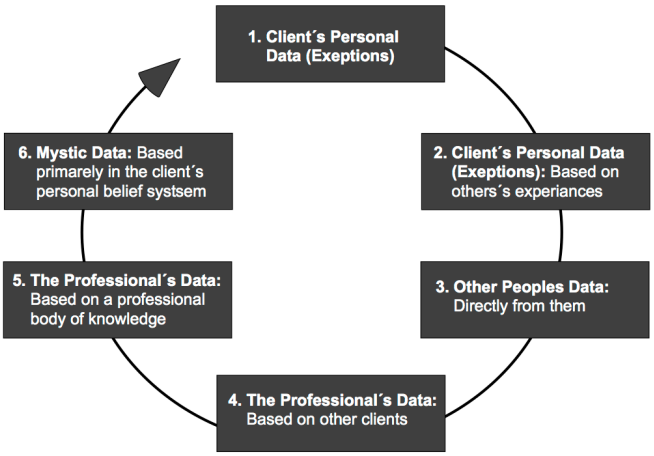

Figure 3. The situations focused data situations circle.

1. **The client's personal data situations (exceptions).** Within the SFBT tradition, this is the obvious source of searching for useful experiences. Typical questions to clients

regarding their exceptions include: When was the situation a little better? Wow! How did you do that?

2. **The client's data situations (exceptions) based on others.** These kinds of data or exceptions are connected to the client's own experience and knowledge but based on observing and getting information from others. Typical questions are: Where have you seen this issue being handled in a good way? What did you see? What was helpful in that situation?

3. **Other people's data situations.** This source of data comes forward when a client has the opportunity to talk with and exchange personal know-how with others who have personally experienced similar situations, difficulties, goals, and preferred situations. Client support groups, for example, provide such an opportunity. Here, the therapist can be helpful in introducing the idea of the meeting and providing information about the possibilities at hand. Typical questions or statements from the therapist in introducing this idea could be: Would you like to meet with other people who share a similar situation? The situation they are in may not be exactly the same as yours, but in some aspects, it is similar! Maybe you can inspire each other with your personal experiences. Maybe you can find out something that is useful for you. Maybe sharing your experience can be helpful to someone else. These and the following types of professional data situations do not fit within the concept of exceptions within traditional SFBT.

4. **The professional's data based on other clients' experiences.** In some cases, it may be clear for both client and therapist that the therapist's knowledge, clinical experience, and even personal experience may be a useful source of ideas for the client. This could include, for example, ideas on how to cope with life or how to achieve the preferred situation. In these cases, the important issue is that the therapist has the client's authorization to speak about his or her own know-how and that the total process is in the client's interests and conducted in a collaborative way. Typical questions or statements from the therapist may include: Would you be interested in what I've learned from clients in situations that I find somewhat similar to yours? Sometimes this can be useful and sometimes not. Would you like to listen for a bit and maybe even ask me about some details?

5. **The professional's knowledge data.** For many reasons, sometimes the above-mentioned sources of exceptions are not sufficiently useful for clients. However, the therapist will still have a professional body of theoretical knowledge that can be potentially useful. Depending on the context, this data can be helpful as long as the client is interested in considering it. Typical questions or statements from the therapist might include: Would you like to consider some ideas that are connected with theoretical knowledge that might be useful? Sometimes this can be useful and sometimes not. So, what do you think, from the perspective or lens of this piece of theory that we talked about? Do you think it fits your situation in some way and could make any practical sense for you?

6. **Mystic data.** Some clients bring the resource of having a relationship with God or another personal belief that provides meaning or hope. Here, the therapist's personal beliefs are not so important; much more important are the beliefs of the client. In most cases, the belief is in God's existence, assuming God's ability, sharing God's grace, and God's inspiration. Medical doctors in Poland in very difficult situations can encourage clients to use this strategy by saying, "We have done all we could. Now you can pray and wait." Following such strategies can be incorporated into a situation by the therapist encouraging the client to turn to his or her God for advice or inspiration. Typical statements from the therapist in the finding of a mystic exception strategy include: So, you said you have strong relationship with your God. I wonder if you maybe can talk to and ask your God for a kind of advice or a sort of inspiration in this situation. So please, when you talk to your God, keep your ears, soul, and mind open and try to figure out your God's suggestions in this situation.

This does not mean that the client's hope and beliefs are not important in the whole process; it is often included in some way already in the conversation about client data situations. It is included, however, as a specific last type of mystic data explicitly to serve two purposes: 1) to connect back to the client's own resources in the form of hope and beliefs, and 2) to connect to the greater understanding that none of us—clients or professionals alike—have all the answers. Mystic data provide another path to an outer source, which possibly exists, and to point out that this does not mean that there is no help; there could still be hope.

Client's Perceptions

How clients express their present perceptions about something is very often not the only perception that exists as a possibility within the client's inner universe and around him or her. Especially at the start of the therapeutic process, the client's perceptions in the present moment are the strongest and represent the client's main focus and energy. Sometimes such perceptions belong to narrations that reinforce the present situations and serve to preserve them. The therapist can then assume that the client's preferred situation very well may require accessing different perceptions and figuring out meanings and what the possible alternative perceptions could be. While the client speaks about his or her dominant perceptions (e.g., his or her currently perceived reason to seek therapy), other perceptions about that something are in the present moment weaker and have a lower energy level, but exist as a possible alternative to the dominant perception. This means that sometimes the therapist needs to first accept and receive the client's current perceptions with their high energy before looking for other ones. By doing so, the therapist can create a context in which the client can experience that within his or her inner universe there exist many more possible perceptions about that something. By the therapist's helping to elicit and reinforce other alternative perceptions, the client can consider which perceptions about that something are useful and desired by him or her. Each perception has its own map with its usefulness as well as its dysfunctions. The therapist should avoid taking sides and deciding between them; instead, the client decides which map should be

crystallized and which should be de-crystallized. Still, the rule that the client is free to choose is the ethical rule that must be applied within the therapeutic process.

Within this model, the therapist can then look for the client's possible alternative perceptions in every aspect of his or her world that requires some cognitive activity (in the widest sense of the word including emotions, behaviors, and bodily sensations) and facilitate the creation of associated meanings for the client. This means that the therapist using the situations focused model will possibly talk with the client about his or her perceptions about very different aspects of his or her situations from the past, present, and future, including problems, solutions, self-pictures, situations, life facts, and significant persons. This strategy will create a multiple session scenario and is especially useful in a context when the therapist will provide continuous support of the change process over time.

Conclusion

The situations focused model aims to draw attention to a perspective on how to use the solution-focused approach in a way that is open and inclusive. It was developed primarily to be used in human services, as in systems of mental health and social work where there are resources and knowledge available that need to be matched with the right client, in the right way, and at the exact point in time at which they could be useful to him or her. It does not aim to include other theories as a part of the solution-focused model; it treats other models of therapy and professional knowledge as resources that may or may not be useful to the client, depending on the situation. It recognizes that change is not about building solutions or getting rid of problems, but for clients to live their lives, and move from less wanted situations to more wanted situations in very particular circumstances, and on that way they will have many experiences, those that can be called success as well as failures, they will have gone through both hard and nice times, and it is great to be able to assist them using the solution-focused approach—since life is life, no less and no more.

References

Anderson, H., & Goolishian, H. (1992). The client is the expert: A not-knowing approach to therapy. In S. McNamee & K. Gergen (Eds.), *Social construction and the therapeutic process* (pp. 25–39). Newbury Park, CA: Sage.

Berg, I. K. (n. d.-a). Hot tips. Retrieved from http://www.sdstate.edu/index/siteindex/loader.cfm?csModule=security/getfile&pageid=238125

Berg, I. K. (n. d.-b). Hot tips II-V. Retrieved from http://sfbta.org/BFTC/Steve&Insoo_PDFs/Insoo_Hot_Tips_ii-v.pdf

Berg, I. K., & Kelly, S. (2000). *Building solutions in child protective services*. New York, NY: Norton.

Berg, I. K., & Miller, S. D. (1992). *Working with the problem drinker: A solution-oriented approach*. New York, NY: Norton.

De Jong, P., & Berg, I. K. (2002). *Interviewing for solutions* (2nd ed.). Pacific Grove, CA: Brooks/Cole.

De Jong, P., & Berg, I. K. (2013). *Interviewing for solutions* (4th ed.). Pacific Grove, CA: Brooks/Cole.

de Shazer, S. (1985). *Keys to solution in brief therapy*. New York, NY: Norton.

de Shazer, S. (1988). *Clues: Investigating solutions in brief therapy*. New York, NY: Norton.

Durrant, M. (1993). *Residential treatment: A cooperative, competency-based approach to therapy and program design*. New York, NY: Norton.

George, E., Iveson, C., & Ratner, H. (1999). *Problem to solution: Brief therapy with individuals and families*. London, United Kingdom: BT Press.

Isebaert, L., & Cabié, M. C. (1997). *Pour une thérapie brève. Le libre choix du client comme éthique en psychothérapie* [For a brief therapy. The client's free choice as an ethic positioning in psychotherapy]. Paris, France: Editions Erès.

Nylund, D., & Corsiglia, V. (1994). Becoming solution-focused forced in brief therapy: Remembering something important we already knew. *Journal of Systemic Therapies, 13*, 5–12. Retrieved from http://guilfordjournals.com/loi/jsyt

Open system. In *Wikepedia*. Retrieved October 15, 2014, from http://en.wikipedia.org/wiki/Open_system(systems_theory)

Sharry, J., Madden, B., Darmody, M. (2001). *Becoming a solution detective: A strengths-based guide to brief therapy*. New York, NY: Routledge.

Situation. In *American Heritage Dictionary*. Retrieved October 15, 2014, from https://ahdictionary.com/word/search.html?q=situation&submit.x=52&submit.y=13

Solution-Focused Brief Therapy Association. (2013). *Solution focused therapy treatment manual for working with individuals* (Version 2). Retrieved from http://sfbta.org/research.html

Świtek, T. (2009). *Sciezki rozwiazan* [Solutions Paths]. Krakow, Poland: Wydawnictwo Akademicka.