The Difficulties and Benefits of Being a Simple Therapist

Plamen Panayotov, Alasdair Macdonald, Boyan Strahilov*

Therapy is the piece of a client's time that s/he decides to share with a therapist.

Abstract

Simple Therapy (ST) was devised by Dr Panayotov and his colleagues since 2009 as a step forward from Solution-Focused Brief Therapy. It's Opening Question is: *What do you think is the most useful question we have to answer first*? Then following on clients' questions and answers the conversation is lead to clients' self-designed tasks and to future contacts. The concepts are discussed along with their convergence with others' work in solution-focused practice. Case examples are followed by practical Difficulties such as power, identity for therapists, not-knowing, usefulness, income, seriousness, and process. Then the Benefits of ST are discussed: reduction in session time, client self-learning, less emotional cost, easier to learn and use.

Introduction 1: What is it?

Simple Therapy(ST) is a distinct way of carrying out therapeutic conversations. It is based on the Thi-Qu-An-D-Ob-Re descriptive model of what therapists and clients actually do together – Thinking, Questioning, Answering, Doing, Observing, and Reviewing; and on an assumption – that if any of these activities can be effectively carried out by clients, therapists should refrain from doing them. It is a step beyond traditional Solution-Focused Brief Therapy, and shares its basic belief in clients and their abilities to be their own best helpers.

ST uses a toolbox of conversational techniques including:

The Opening Question: *You know, my job is to ask questions, and they need to be as useful as possible, for you in this case… so, what do you think is the most useful question you can hear from me (I can ask you) right now?*

Echoing: Whatever question is stated by the client, is *cited* by the therapist, using as close as possible its original phrasing and wording.

The Therapeutic Wheel: The therapist believes that following the *Client's Questions – Client's Answers* spiral forms the Highway to Solutions, so he lets clients practice it as much as necessary. The more a client does it, the better she becomes in doing it.

Whenever clients want to know why their problems exist, the Simple Therapist relies on the clients' own answers (So, what do you think is the most useful explanation to your problem?), and on the Thesaurus of Useful Explanations (a collection of simple explanations, proposed by other clients). These include (but are not limited to):

- The Final Cut of the Ockham's Razor (used by the therapist only when clients want an explanation to their problems): *Everything happens first, and then becomes a habit.* This tool is usually not used in its declarative form displayed here, but as a series of questions like: *When did this habit happen for the first time?* and *How often does this habit happen lately?*
- *Because I am (you are, we are) alive!*
- *This is my (your, his/her, our) energy.*
- *Because we (you, they) love each other.*
- *Because I (you, he/she) say so!*

When clients are not interested anymore in explaining their difficulties, what usually happens is they start searching for solutions, usually stating:

The variation of the Awakening Question: *Now, what are we going to do about it?* asked by clients themselves if and when they arrive at it.

What about the Classical Solution-Focused Questions?

When and only when, clients decide to demand from the therapist that he uses his professional training and questions, he poses: *Exceptions-Finding Questions, the Miracle Question, Coping Questions, Scaling Questions, Relationship Questions, the Best Hopes Question, Competency-Eliciting Questions,* etc. Throughout the conversation, however, the proposal for clients to come up with their own useful questions remains valid, assuming that clients' questions have high priority over any therapist's question.

Prescriptions: *Several self-prescribed client's tasks, preferably written down by them.*

The Follow-up Permission Quest: *If you agree that I will ask you … weeks from now how things are going on for you, and was our conversation today useful for you, please write down your phone-number.*

The Follow-up Questions (asked distantly, or in person): *How are things going on for you now?* and *Was our meeting(s) useful for you?*

(http://en.solutions-centre-rousse-bulgaria.org/files/simple_therapy.pdf has a more detailed description of these tools)

Introduction 2: The Miracle Accident's Daughters: a Tale of Two Questions

'… you always need to be constantly aware of things that accidentally happen to you. And to take advantage of whatever accidentally happens… The Miracle Question is an example – a client said something about 'it would take a miracle', Insoo heard that word 'miracle'… these sorts of accidents. If we hadn't been prepared to look for accidents like this, we would have never learned to use the Miracle Question, it would have faded away… So, you have to be always aware of accidents, as you are walking your half steps at a time, and take advantage of them. Then the accidents may turn you away from what you think is your final goal, but end up at another goal that is just as good… or better.'

Steve de Shazer, personal communication, 1994

While the above Miracle Accident's Content led to formulating the Miracle Question, a 'trademark' of Solution-Focused Brief Therapy, it was the same Accident's Process that gave also birth to the Opening Question, a key tool of ST:

Content: The client wanted to be asked about her miracle. Insoo heard that. She asked about the client's miracle… The MQ came into being.

Process: The client wanted to be asked her own question (that happened to be about her miracle at that time). Plamen heard that. He asked clients about their own questions… The OQ came into being.

Introduction 3: Timing

We heard this story from Ben Furman: *Sara Vataja, a child psychiatrist and her husband had a client, an elderly lady who did not respond to the Miracle Question despite many tries. She just seemed to want to tell her story. So the therapist went to talk to the team and asked them what to do. The husband in the team said 'Why don't you ask her how much time she needs to tell her story so that she can then allow you to ask your questions?'. The therapist returned and asked "As you have noticed, I have tried to to ask you several times this question about how you'd like to see your future unfold…" "Yes, I sure have noticed", said the client...and after that came the mutual problem solving of what to do about this discrepancy to which the*

client had a perfect solution. She said that she needed three sessions to tell her story. The therapist said 'Okay' and that is what they did.

ST assumes that good and bad questions do not exist. There are only questions that are on time (the client's time, of course), and questions that are out of time. The twin-questions, the MQ and the OQ, share a common origin, but differ in this: the MQ (like any other question) can happen to be on or out of time, while the OQ is always on time.

Historical note: Boyan Strahilov remembers a discussion with Steve de Shazer about what the therapist could do in case of difficulty about knowing what to ask the client. There were different ideas but one of them was very interesting. It was a kind of self-help tool for the therapist to ask better questions and was presented as a self-referent question: "If Steve was put into my place in front of the client, what he would ask the client that could be useful?". With ST we put the client in Steve's place to ask similar useful questions.

Gale Miller and Steve de Shazer (1998) wrote about the spread of solution-focused therapy as a rumour, leading to different and perhaps creative 'misunderstandings'. We wonder if a similar process will occur with ST.

CONVERGENCE WITH OTHER DEVELOPMENTS IN BRIEF THERAPY

'So Plamen, it's taken me a few years but your workshop in Dresden (and our conversations) did convince me that there was method in your madness and I did promise myself to give it a try! And today before the massed ranks of the BRIEF Summer School I asked my client "What is the best question I can ask you now?" The client came up with exactly the sf future focused question, that I would have asked if I had known what it was. So thank you, Plamen. Chris.' (Iveson 2013)

The BRIEF group in London have been teaching and learning in Solution-Focused Brief Therapy for many years. They use research methodology to study ways of reducing their questions. As described in Franklin et al (2011) they now teach students to start with the 'Best Hopes' Question instead of the Miracle Question (*'What are your best hopes from what will come out of this session today?'*). This is a version of the question most professionals use to start the contracting process: taxi drivers: "Where to?"; shopkeepers: "How can I help you?". These are all questions related to outcome. In English 'from this session' implies future activity; 'for this session' implies during the session itself and so is different in scope. These constructions may differ in other languages. This is followed by repetitive questions about '*What else*?'. '*How will you know that these hopes have been realised?*' (Description, description, description). '*What have you already done that might help bring them about?*'. (Description, description, description). Then scaling enhances the details of these questions.

They no longer take a break near the end of the session although they may pause briefly for reflection. They have modified their end of session feedback to omit compliments, giving only a summary of the client's preferred future. Thus part of their current model is already similar to ST. Perhaps if clients mention 'hope' in replies to the OQ, the 'best hopes' question will be a possible next step for the simple therapist, too.

Solution-focused situation management: finding cooperation quickly (Macdonald 2011). This situation management tool devised in 2007 has similarities to ST.

Many managers will find that a wide variety of staff will come to their office without appointments to share various problems and anxieties. It is necessary to respond to these enquiries appropriately and respectfully, in ways that encourage self-reliance rather than dependence on management to address issues. In finding cooperation quickly the key questions are:

- *What is the problem?* Ask for a behavioural description:
- *What happens?*
- *Who does what?*
- *When does/did it happen?*
- *Are we certain that this is happening?*
- *How do we know?*

Usually by the time you have obtained the answers to these questions your colleague has become calm enough to think about the situation as well as reacting to it.

- *What small/first step will show us that the situation is moving in the right direction?*
- *What can be done?*
- *Who can do it?*
- *What is the next step in this solution?*

The final questions relate to ensuring that the problem is successfully resolved.

- *When do we review this?*
- *What do we do to review this?*

In general, these conversations last about five minutes. A week later it is likely that the problem has almost been forgotten. Of course, new problems with something else will have arisen, which is the nature of the world of management.

Difficulties

Clinical practice reveals high levels of acceptance of these tools among diverse kinds of clients, increasing their involvement in co-constructing solutions, shortening of therapy as a whole, as well as individual sessions, and eliminating many misunderstandings between therapists and clients. Stated differently, ST takes a step from 'The death of resistance', declared by Steve de Shazer in 1984, to 'The birth of assistance'.

Even so, many therapists when acquainted with ST remain quite reluctant at using its tools, sometimes actively resisting, or just neglecting them. Here we try to understand this discrepancy between clients' acceptance and therapists' resistance to these instruments.

A Freudian Walk… without any Freuds around (a case example):

Petar S. is a mid-40s-aged painter, icons-restorer, owner of an advertising firm, and a very good bass- and guitar-player in an amateur jazz-band. Over the last ten years or so he was counseled on many and diverse issues, including depressed and obsessive states, anxiety spells, drugs and alcohol misuse. He usually came for a brief single session, then disappeared without a notice, and after several months coming back to state he solved his previous difficulty, now coming to address the next one. Then he stopped coming altogether… four years later the therapist (Plamen) happened to meet him in a café, and he said:

'You know, I've been quite okay most of the time through these years,but it also happened six or seven times that I decided to come to you for a session.Then I started walking through the park to your office. And I thought to myself 'What is he going to ask me now?', and then 'So, what shall I answer?'. Then every time, even before reaching the middle of the park, I already knew exactly what I have to do, and so, instead of coming to you and losing any more time, I turned back and just did it… without you ever knowing about it!'

'And you also saved the money for these sessions, too… but I have lost it!'

They both laughed.

Boyan Strahilov asked this one day at the end of a session: 'What do you think is the most useful task I can give to you till next time we meet?'. The client not only stated the task but also wrote it down herself.

Alasdair Macdonald uses the OQ when interviewing counselling volunteers. Most laugh briefly and then reply with some form of question about their motivation for the work. This is a good start to the interview and is useful for planning their first tasks. Perhaps the OQ is effective in focusing the client's attention on their own motivation for change.

Most difficulties with the Opening Question arise from its many and diverse implicit meanings.

Clients are usually tense about their inability to reach a solution without help. The OQ suggests and implies (among other things): *'You know, you are not the only one in this room who has no idea what to do… I am in the same boat! I also don't know what to do. You need to help me'*. This shift from helper to help-needier is a difficult step to do. The benefit of *'we are equal now'* is that we can discuss the situation from a totally different perspective – two (or more) confused people trying to get together out of the muddle they are in… and no Big One there to help them!

The question has been asked "What is your stance when confronted with a situation where the client is not the person sitting in front of you?". It does not seem that this makes any difference. People come to us to have useful answers to their own questions, and it doesn't matter if we call someone, or another, a client – this is a distinction WE (not clients) do, so it is not important.

And here come THE DIFFICULTIES OF BEING SIMPLE:

Power

Empowering of clients within the conversation here and now disempowers the therapists. Therapists just don't want to give the power over the flow of the conversation to clients. They are afraid that the client may 'lose track', or 'go into endless problem talk', etc. - in fact clients almost never do this when they are allowed to choose and decide the direction of the conversation.Although the goal of the therapist is improving welfare for the client, they want to be part of that success. They do not want to be disempowered. The OQ may be used as a 'rescue tool' in hard times or when other questions fail to get a useful answer. When therapists are very experienced and sure of what they are doing, it has small chance of being asked.

Choice and control are important to clients and are associated with better outcomes in therapy (Seligman 1995). ST maximises this effect but the therapist input is less. In Sweden a major government initiative using cognitive-behavioural therapy has been withdrawn, because the outcomes were worse than the previous system offering choice between a variety of therapies.

Identity

Doing ST can lead to a professional identity crisis: Therapists start wondering 'Am I a therapist anymore?' In a way, they are right – you stop being a 'therapist', and you become some kind of a 'mental rehabilitator' – helping people learn how to help themselves.Sometimes therapists may feel disloyal to their trainers if they do not push their original training model. Or therapists avoid just echoing a client's question, if they think it is inappropriate. They rephrase it instead (which may invalidate the client) to match their training and assumptions. Therapists think the OQ is difficult for clients (not for therapists!),

so they want to make it easier for clients by asking their professional questions, which they perceive as 'easier' for clients. Therapists may feel irresponsible if they let clients do their job.

And from our experience a “solution” for some young therapists is to ask "good questions" to the clients and push them to give answers, not to let them ask questions themselves. Using ST involves trying to turn this “habit” off.

When the therapist focuses the conversation at whatever his background tells him is important, the conversation has a more or less stable focus. When the client is to focus the conversation, it becomes much more dynamic, sometimes changing in a few seconds. This demands a great deal of fluidity and flexibility on the therapist's side, which may be seen as ‘a difficulty’. The benefit, however, is that the conversation becomes much more lively, unpredictable, and fun after all.

One’s identity as ‘a therapist’ is important. However, note Chris Iveson’s story of the man who told him ‘when you are a good therapist, you are invisible to me: it’s just me thinking aloud. When you say the wrong thing, you interrupt my reflection and you become visible.’ SF therapists are accustomed to carry out apparently small interventions which nevertheless lead to change. Therapists who favour other models may not comprehend this style. It is important to remember that most clients have very little interest in our models of therapy or our theoretical arguments. They want to see results, not theorising.

Not-knowing

In Solution-Focused Brief Therapy, not-knowing is widely accepted as a stance, a position the therapist takes, or a role he plays. The Opening Question implies the therapist *Really* knows nothing (not even what to ask). Not knowing is something we all were taught (throughout our whole education) to be ashamed of, guilty about, and to avoid. Not knowing is frightening for many therapists, especially academically trained doctors and psychologists. Doctor training does expect them not to know until history and examination has been carried out, whereas many psychologist trainings imply that you will always ‘know’. This is surprising, given that there is a huge body of psychological knowledge and research and no-one can know it all. As regards other disciplines, nurses and non-specialist counsellors are used to not-knowing in an intellectual sense.

There is a story from Gale Miller that therapists are like carpenters. Every client comes to the therapist with its wood (problem) and therapists use tools to deal with the wood. And a question emerged –*What will happen if the therapist gives his own tools to the client or ask the client to bring his tools for the wood?* Probably it is better (for clients) when we (as therapists) teach clients in craft instead of showing our own mastery to them. However nowadays therapists prefer to show their own mastery somehow - "I did something good for the client".

Most students of Steve de Shazer and Insoo Kim Berg remember how often they spoke of the importance to be curious. But therapists show curiosity by asking their own questions (miracle, scales, etc.). So, how to be curious without asking our own questions? Shall we try to find a way to understand client's questions then? Probably clients have better questions than we have. We think that it would be good to find them. As we see it, ST is just one step in this direction.

As stated in "Burkean Dialectics and Solution-Focused Consultation" by Gale Miller: "…Consider, for example, Panayotov's (2013) examination of the metaphor of client as expert. He points to incongruity in asking if clients are experts on their lives, then why do sf consultations begin with questions that practitioners think will be useful to clients?. Doesn't it make more sense for practitioners to ask clients, "*What do you think is the most useful question I have to ask you*" (Panayotov, 2013, p. 18)? He further unsettles conventional wisdom in discussing how the sf approach is a toolbox that practitioners draw from in interacting with clients. He notes that master crafts-persons use existing tools and also sometimes make new ones in addressing diverse and unique situations."

Sometimes "Solution" is a tricky word. Sometimes the solution is to make change, sometimes it is just to accept things as they are, and sometimes it is to have the skill to ask useful questions. There can be a difference between "solution" for the therapist and "solution" for the "client". Nowadays, in developing Simple Solution Focused ideas we are much more interested in *what was/is/will be useful* for the clients instead of being interested in questions like "What is better?". We believe that sometimes for the client it is more useful to do other things instead of just trying to be better. "What is better?" can be seen as a characteristic of the model and as a habit in the therapist of asking this question but it might not be helpful for the clients. Trying to keep Steve's idea of "involving clients in hard work" alive we give the clients the possibility to decide how to approach their problems/difficulties and choose what is the useful way to work hard.

The 'ready-made' SF-questions can be helpful only IF and AFTER a client stays firmly on his "I don't know" response to the OQ, or when they explicitly say they want us to do our job. It is good to always inform them, however, that throughout the session, if they happen to have their own useful questions, they must stop right away, and ask it! Clients need to have the sense that their own questions, that is their own 'what do I want…' have an EXTREMELY HIGH PRIORITY over any set questions. This can be highly validating and empowering thing we can do for them!

Usefulness

All men know the advantage of being useful, but no one knows the advantage of being useless.

Chuang Tzu

The Simple Therapist becomes useless for his clients quite soon. The moment clients feel confident they can ask themselves the best possible questions, they forget about their therapist. Becoming useless is a loss of perceived power and status. Most people find this undesirable, even when it is unavoidable. It may have serious consequences. In the United Kingdom the Improving Access to Psychological Therapies (IAPT) initiative had the effect (possibly deliberate) of sidelining trained professionals such as doctors and psychologists. They were replaced, at least in theory, with Psychological Wellbeing Coordinators, who had less than one year of training in cognitive-behavioural therapy. As a result, service planning is no longer conducted by anyone with any theoretical knowledge of psychotherapies. Local services in some areas have been distorted to the point where the distinction between types of psychotherapies has been lost and all therapy is assumed to be short-term.

This leads also to...

Income

ST leads to a drop of income for the therapist from the particular client. Sessions become even less in numbers, and briefer in length. Single-session therapies are not rare exceptions, they become quite common. Sometimes the workers then fear to lose status or money. Strahilov, Panayotov, Watson, and Decker (see above) all expected further sessions with their clients.

A loss of sessions and therefore income is a real threat to a professional therapist. However, Steve de Shazer said that all brief therapists are always on the look out for more clients, so this is not a new phenomenon. The Brief Family Therapy Clinic in Milwaukee relied on word of mouth advertising in their neighbourhood and did not report any difficulty in finding clients.

Seriousness

> *Work consists of whatever a body is obliged to do. Play consists of whatever a body is not obliged to do.*
>
> Mark Twain, *The Adventures of Tom Sawyer*

Following Mark Twain’s definition, ST is Play: Clients are not OBLIGED to do the questions, so if they do, therapy is not Work anymore, it becomes Play. Most therapists take their work so seriously, that they don't want to allow this. This Difficulty of Being Simple is rooted in the widespread Importance of Being Earnest.

Playfulness is linked to learning and to creativity. So play for the client can be very useful. It is more difficult for the therapist, who has to avoid seeming to treat distress too lightly. This is

sometimes an issue for Positive Psychology, whose emphasis on ‘count your blessings’ and ‘you do not have so much to worry about’ can alienate those in significant difficulty.

Erickson used many playful metaphors, although being careful to present them in non-playful language. One of his famous examples is engaging a schizophrenic inpatient who believed he was Jesus Christ by saying ‘Iunderstand that you know something of carpentry. We need your help with a renovation project.’ The Mental Research Institute in Palo Alto developed strategic therapy by ignoring theories of mind in favour of theories of interaction as used in salesmanship and advertising. Many of their paradoxical instructions were developed in playful talk behind the screen about how the client was currently dealing with difficulty. A modern master of such prescriptions is Brian Cade, one of the leading UK family therapists in these last 30 years. His publications show playfulness and humour as powerful tools for the brief therapist. He has handouts for clients in some situations which illustrate ‘what not to do’, saying that after many years consulting with families he has become an expert in failed approaches.

ST is also perceived as a threat to trainers. Suddenly they have to face a brief and logical intervention which makes much of their previous teaching unnecessary.

A linguistic trap: ‘we need to talk’ usually means that talking is over and action is going to be taken. ‘X needs to talk to somebody’ is taken to mean ‘talk to a professional’ whereas in fact many people simply need to talk to someone who replies in a new way. This may be a professional, which is seen as a failure of the person to cope. However, it might also be a friend, a relative or any otherresponder, not necessarily a therapy professional. Many ordinary people talk to their dogs with benefit. Freud had regular consultations with a otolaryngologist and numerologist, whose advice may well have been difficult to apply to psychotherapeutic clinical situations. ST demonstrates that one new response can be enough to facilitate new thinking about a situation.

As therapists will have more success for less work, this may answer the fear that they will lose income.We suspect that health care managers will be slow to understand that good results are important to a service. They only want to see their workforce being active; effectiveness, especially in psychotherapy, is far from their thoughts. A colleague attracted a visit from the Chief Executive Officer because his therapy group was so successful, but he has since lost his job because they want to use his office for management activities.

Process

Most conversations we participate in (not only therapeutic ones) are organized in a millennia-old habit of sequencing a Question – an Answer – a new Question – another Answer – (with the questions usually asked by one of the conversing, and the answers provided by another)

… until a conclusion is reached. The process is actually the same as the ancient Greek tradition of Thesis – Antithesis – Synthesis.

ST proposes a very unusual and perceived as weird conversational process: both questions and answers are provided by one of the conversing – the client, with the therapist just observing what happens. This is probably the greatest difficulty of all, as it appears on a level usually unnoticed and unconscious. It takes a lot of disciplined practice to overcome the old habit and stick to this new and unusual one.

BENEFITS

Reduction in session time

ST usually takes less number of sessions, compared to classical Solution-Focused Brief Therapy. As stated above, single-session therapies are not rare exceptions, but fairly common. With ST, sessions also become briefer: session breaks are rarely needed, and the moment clients have their prescriptions, they usually lose interest in staying in the therapy room anymore.

Client self-learning

ST helps clients not only find solutions to their present problems, but also practice the Thi-Qu-An-D-Ob-Re cycle, which allows them become solution-focused themselves, and improves their abilities to address effectively other hardships in their future.

Less emotional cost

Most traditional forms of therapy are practiced at high ‘emotional cost’ for clients. This, naturally, burdens their therapists, too. Solution-Focused Brief Therapy radically changed this direction for both therapists and clients. Following this line further, the Simple Therapist is quite at ease while working. His job is usually fun and joy. Getting ‘stuck’ is something he has long forgotten about. This emotional atmosphere is shared by his clients, making therapy not only ‘emotionally free’, but also an experience worth to remember for both.

Easy to learn and use

The 'more gifted' therapists have the intuition of guessing right what the client wants them to do in a certain moment. Others do not possess this intuition. They can get quite satisfactory (or even better) results by directly asking clients what they want from the conversation at hand, instead of guessing. So everyone can become a useful therapist in quite a simple way!

Another benefit is: one always has a way out of 'stuck situations', sharing his 'stuckness' with the client, and relying on her to get him out of it.

CONCLUSIONS

Fairly simple and easy to grasp and use, ST imposes significant emotional and cognitive demands on therapists.

The market pressure for quick and effective solutions-building approaches is the main factor working in its favor.

Even though difficult for therapists in many ways, ST is also beneficial to both clients and therapists, so it can be given a chance, and its results evaluated in diverse contexts.

Presumably we have no objection if the model is taken up by non-sft practitioners also.

We may conclude that ST is a bit ahead of its time, even though its main tool, the OQ, is always on time!

This reminds us of the paradoxical nature of life…

… As therapists, what do you think will be the next small activity we have to get rid of in our everyday practice, and let clients carry out probably better than us?

*The authors:

Dr Plamen Panayotov, MD, 20 Tutrakan Blvd, Rousse 7003, Bulgaria, +359 878435014, +359 82 845898, plamenpan@mail.bg http://en.solutions-centre-rousse-bulgaria.org/

Dr Alasdair J Macdonald MB ChB FRCPsych DPM DCH, 27 Clarendon Avenue, Weymouth DT3 5BG, +44 (0)1305 813373, 07738 938 376, macdonald@solutionsdoc.co.uk www.solutionsdoc.co.uk

Boyan Strahilov, PIK Center, Sofia, Bulgaria, +359 898481111, boyan@pikcenter.eu www.pikcenter.eu

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Websites:

Furman, B. http://www.benfurman.com/

Solutions Centre Rousse Bulgaria. http://en.solutions-centre-rousse-bulgaria.org/