# POSSIBILITIES AND SOLUTIONS: THE DIFFERENCES THAT MAKE A DIFFERENCE

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## ABSTRACT

The purpose of this paper is to de-construct the confusion we have noticed among our students and therapists in Mexico and Spain, in regards to the differences between Solution-Focused Therapy and Possibility Therapy (previously known as Solution-oriented Therapy). In order to achieve our didactic objective, the aims of our paper are two-fold: (1) to describe the basic premises and therapeutic interventions of each model; and (2) to point out the "differences that make a difference" in order to clarify the readers' views about the two models. In addition, the paper includes a short interview with Bill O'Hanlon.

**Keywords:** Solution-focused therapy, Possibility therapy.

## INTRODUCTION

There is a large quantity of books and articles about therapies which search solutions as the priority, just in the O'Hanlon's web page[1] there are more than 75 listings. But, not all the papers are focused on the same kind of therapy. Although Solution-focused and Solution-oriented therapies are both oriented or based on solutions; they are not synonymous. In addition, Possibility therapy and Inclusive therapy could be categorized within this kind of therapies.

What are solutions? For some time the group of Milwaukee has described them as the behavioral or perceptual changes constructed by therapist and client in order to modify the unsuccessful ways of coping with a difficulty. The new construction allows for a different way to experience the complaint that brought the client to therapy (de Shazer et al., 1986).

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[1] Bill O'Hanlon, M.S., http://www.brieftherapy.com http://www.billohanlon.com

The main therapists of Solution-focused therapy have been Steve de Shazer and his colleagues from the Brief Family Therapy Center (BFTC); while in Solution-oriented therapy it has been Bill O'Hanlon, who is also the author of Possibility therapy and Inclusive therapy. If we consider the first books (de Shazer, 1985; O'Hanlon and Weiner-Davis, 1989), the work of de Shazer and O'Hanlon could seem more similar; nevertheless, both authors have indicated that there are some differences (Beyebach and Rodríguez-Arias, 1991; Rodríguez and Wainstein, 1993). Still, the differences between their work are not easy for trained and untrained readers. For example, Gingerich and Eisengart (2000) in their review of controlled outcome studies of Solution-focused therapy included papers identified by the own author as Solution-focused or Solution-oriented. Thus, it is important to look at the differences and similarities between these two models. As therapists, we feel the need to disclose that we do not disagree with any of these two models. For example, the first author of this paper is a cognitive behaviorist who has tended to use more O'Hanlon's approach than SFBT; while the second author has used SFBT more frequently than O'Hanlon's approach.

The paper is divided into three sections: (1) description of procedures; (2) similarities and differences between the two models, and (3) interview with Bill O'Hanlon. A short conclusion follows.

## DESCRIPTION OF PROCEDURES

### Solution-Focused Therapy

This therapy model started with some influences from Problem-focused brief therapy practiced in the Mental Research Institute's Brief Therapy Clinic (MRI) and it has evolved towards solutions philosophy (Estrada, 2006). In 1978 de Shazer, his wife Insoo Kim Berg and their colleges (Elam Nunnally, Eve Lipchik, and Alex Molnar) founded the BFTC, as a research and therapists training center.

There are three basic tenets that usually guide Solution-focused therapy: (1) If it isn't broken don't fix it; (2) If it works, do it more; and (3) If it doesn't work, stop doing it and do something different (Berg and Dolan, 2001). SFBT is a future-focused, goal-directed approach to brief therapy, it is based on resiliency and client's own previous solutions and exceptions to their own problems; many techniques can be integrated into SFBT as long as they do not violate its fundamental principles (Trepper, Dolan, McCollum and Nelson, 2006). Implementation of this therapy should never be done in a rigid way. As de Shazer mentioned, SFBT can be seductive because the basics are easy to learn, but the art of doing it well can require many years of supervised experience (Trepper et al., 2006). We recommend reading classic and recent publications for a thorough understanding of this model. The following authors have written extensively about SFBT: Berg and Miller, 1992; Berg, 1994; de Shazer, 1985; 1988; 1994; George, Iveson and Ratner, 1990; Selekman, 1997, and the recent ones Berg and Dolan, 2001; Beyebach, 2007; Carlson, and Sperry, 2000; de Shazer, Dolan and Korman, 2007; de Shazer and Isebaert, 2003; Jackson and McKergow, 2007; Lee, Greene, Mentzer, Pinnell, and Niles, 2001; Lee, Sebold and Uken, 2003; Lipchik, 2002; Macdonald, 2007; Nelson, 2005; Sharry, 2001; Sharry, Madden and Darmody, 2003.

*The first session*: After a brief social phase, the therapist develops some objectives (keys to the success): a) the building of cooperative and respectful therapeutic relationship, b) the definition of the complaint (establishing the demand for treatment) c) the creation of objectives, and d) constructive search of exceptions.

*How is the therapeutic relationship constructed?:* It is distinguished for being cooperative. The aim is to create a confident environment where the clients could feel they are listened to and are comfortable. To do that, it is important to consider when the client is or not motivated to go through with the therapy: is the client a customer or a visitor? (de Shazer, 1988).

*How is the demand of treatment defined?:* The next step is to establish the demand of treatment. The therapist should make the client provide the most accurate, detailed and concrete information about his or her problem (de Shazer et al., 1986). A usual question is: What brings you here today?

*How are the treatment goals defined?:* After establishing the definition of the problem; the therapists translates it into a definition of the solution. The next step is to define the treatment goals. In other words: what's the concern that brings the client to therapy, what does the client want to get out of therapy, and what are some of the ways to get there? Goals should be important to the client; be described in an interactional way inside a social context; they should be brief, simple and reachable; be constructed in terms of "having something" instead of "quitting something"; they should be described as the beginning of a new behavior instead of the end of an undesired behavior; and, finally, the client should be aware that this might require hard work and a great effort (Berg, 1994).

*How are exceptions searched?:* Exceptions are those unique situations in the client's life when the complaint doesn't happen or, when it happens, it does so at a slightly more bearable degree (de Shazer et al., 1986). Exceptions are a key component of SFBT. The therapist task consists of identifying the effective things done by the client; emphasizing them, amplifying them, and attributing success to the client. Finally, the therapist will be looking for ways in which the client can continue making exceptions happen, as well as looking for more exceptions. Any exception is welcome because a small change can lead to a bigger change.

*Miracle question:* The future projection is one of the main characteristics of Solution-focused therapy. To reach that objective, the Miracle Question is ideal (de Shazer, 1991, 1994). Its purpose is to shift the conversation quickly and easily into a future when the problems are solved. In the BFTC[2] web site, de Shazer gave some instructions on how to use this question in a correct way. From our point of view, the Miracle Question could sometimes seem like a rigid technique. Some clients may not feel comfortable with this questions because it can look like an imaginary game. Ideally, one would ask the client permission to try something new. The key is not to ask about the miracle, but instead ask about the things that might happen after the miracle. For example, "How will you notice that some type of miracle has happened and the problem that brought you to therapy has been solved?" After a detailed description of the "solution", the therapist goes back to the present and looks for exceptions. He/she might ask something like, "When was the last time (perhaps days, hours, weeks) that things were a little bit like that (when the miracle has happened and the problem has resolved)?" Those questions give us a behavioral narration about how things will look like when the problem is solved and the differences in the client's life when this happens.

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[2] http://www.brief-therapy.org

Like with any other therapeutic intervention, it is important to note that this technique should not be utilized with all clients.

*Scaling questions:* This tool was designed (de Shazer, 1988, 1991, 1994) to evaluate some subjective or abstract aspects (Berg, 1994), where 10 equals the achievement of all goals and zero is the worst possible scenario. This is one of the most useful tools of a Solution-focused interview. It helps to asses the perception of therapeutic progress and to establish with clients who establish unspecific objectives. For example, when using scale questions it is possible to evaluate the self-esteem level, client's trust to achieve or to maintain the change, therapy progress, client's disposition to work in therapy, and suicide risk, among others (Berg, 1994).

*Final Message delivery*: Forty-five minutes into the session, the therapists usually make a pause. The purpose is to design the final message. It includes compliments and homework tasks. In general, these messages are short, to the point, and avoid starting new debates or dialogues.

*Second and subsequent sessions:* In subsequent sessions, it is common to begin with the question: What things have been improved? Or, What's better, what's the same, and what's worse? These questions presuppose that change has already taken place and they are considered very useful. The main objectives in all subsequent sessions are: (1) To construct the interval among sessions as periods where improvements happen; (2) To prove if the things done in the last session where effective; (3) To help the client specify the things that help him get the achievements and recognize which of them he should keep doing; (4) To analyze if enough change has occurred and if it is still necessary to continue with therapy; and (5) To avoid talking about problems when clients don't describe improvements. (de Shazer, 1994)


## Possibility Therapy

We are talking about Possibility therapy rather than Solution-oriented therapy because O'Hanlon preferred to stop using the name Solution-oriented therapy to avoid the confusion with Solution-focused therapy (O'Hanlon and Bertolino, 2001).

Describing the process of Possibility therapy is more complex than describing Solution-focused therapy. O'Hanlon does not work with a scheme for each session because for him all methods, all techniques are possibilities that can be utilized. We can hear O'Hanlon say in many workshops: "This technique is effective, except when it is not." In other words, the therapist can try different interventions and not all of them will work for all clients and for all clients' issues. Therapist's flexibility is "a must". Flexibility in terms of looking for different ways to open up possibilities for clients' change and progress.

*How is the therapeutic relationship constructed?:* In Possibility therapy the therapeutic relationship is constructed in a respectful environment, monitoring both verbally and non-verbal messages to ensure that clients are feeling heard, validated, acknowledged, and understood. This therapy is mainly about acknowledging and validating the clients' experience and ideas about their lives, while ensuring that the possibilities for a change are discovered and amplified. It is only after the client feels validated and acknowledged that he/she can delve into problems and solutions. (O'Hanlon and Beadle, 1999).

*How are the treatment goals defined?:* "If you don't know where you're going, you'll probably never get there." To prevent such a bewildering result, therapist and client should be

clear about therapy goals (O'Hanlon and Beadle, 1999). Goals must be mutual; that is, all parties must agree that the goal is relevant and achievable. Goals often include time elements: how often (frequency), when (data/time/deadline), how long (duration). They must be defined in terms of resolving the concern that brought the client to therapy, as well as the ability to assess progress. Recently, O'Hanlon has changed his language about goals and prefers to call them "directions", since that word provides a sense of openness and flexibility and feels less rigid (O'Hanlon and Beadle, 1999).

Components of Possibility therapy: In the interview, O'Hanlon described six main components of Possibility therapy:

1. Acknowledging, Validating, and Valuing: It is important to attend carefully to clients, acknowledging their points of view and feelings. It is also important to communicate a basic linking for and valuing of the person. One can also realize that the points of view and feelings of the person are valid or within the realm of normal human experience.

2. Clarifying Concerns, Complaints and Goals or Directions: working collaboratively we can explore client's concerns and complaints, that is, what they believe is troubling enough to have sought your help. The idea to seek help may be someone else's and it is just as important to explore this. Then find out what the clients' (and/or the people who think the client needs help) view of what would constitute a successful outcome. Get such goals, outcomes and destinations in action terms (so that one could see and hear what would be happening at that time). If the client doesn't want goals that are so specific, one can always inquire about directions that would be preferred rather than specific outcomes

3. Changing the Viewing, the Doing and the Context: Help people challenge patterns of their meaning-making (stories), what they are attending to, patterns of action and interaction, and any aspects of the context around the problem (cultural, gender, family background, neurological/physiological, spiritual aspects of clients' lives).

4. Evaluating Progress, Results and Outcomes: Check in with people throughout the process to find out whether what you are working on with them is relevant and helpful. Use scaling and percentage questions, as well as feeling questions to assess how things are going according to clients.

5. Planning Next Steps: Plan assignments for out of session experiments. Ask about when the next meeting should be according to them. Ask people whether they want to come back, whether they have made enough progress in the direction they wanted to stop the process of counseling or therapy or to take a break. Plan follow-up contacts and relapse prevention or recovery.

6. Terminating Treatment: Stop treatment by mutual agreement, leaving the possibility open for return for any future problems or recurrence of previous problems.

O'Hanlon added the next seven steps in Possibility/solution based therapy:

1. Create an atmosphere of change and possibility (through language, assessment methods and nonverbals)
   a) Use possibility language
   b) Assume change can happen

    c) Do not assume irrevocable damage or pathology
    d) Ask about future preferences for therapy outcomes as well as for life
2. Acknowledge pain, suffering, problems, explanations, feelings and points of view while keeping possibilities for change open
    a) Validate current reality without assuming that things will remain the same
    b) Listen without trying to make things more cheerful or better than they seem to the person who is speaking about the situation
3. Orient to preferred future and goals
    a) Find out what people want out of therapy or what the minimal change they would expect
    b) Find out if people have any unrealized hopes and dreams that might be relevant to resolving the problem
4. Track problem patterns (viewing/doing/context)
    a) Have people teach you how to "do" the problem
    b) Find typical viewpoints of people involved in the problem situation
    c) Find where the attention is focused in the problem situation
    d) Find out what happens around the problem situation socially
    e) Find any time or spatial patterns or regularities in the problem situation
5. Elicit solution patterns (viewing/doing/context)
    a) Explore exceptions to the problem
    b) Explore positive coping methods and times
    c) Find any context in which the problem would not occur
    d) Find out where attention is focused in non-problem moments or times
    e) Identify any alternate stories or ideas that are different from typical or problematic stories or ideas
6. Connect with or evoke motivation
    a) What are people involved in the problem situation motivated for and what are they motivated away from or what to avoid?
    b) Experientially connect people to their motivations in order to bring about change in the problem situation
    7. Introduce or notice small changes
    a) Identify anything anyone involved in the problem situation is willing or able to do in order to make a small change in viewing, doing or context
    b) Usually this will involve some rigidly repetitious aspect of the problem situation
    c) It might involve deliberately taking some action that is part of the solution patterns evoked or identified

About Inclusive therapy, in his book, O'Hanlon explains three basic methods and twenty-six applied methods from them (O'Hanlon, 2003). The basic methods are:

1. Give the person permission to and permission not to have to experience or be something. For example, you can say "I can feel angry and I don't have to feel angry"
2. Suggest the possibility of having seeming opposites or contradictions coexist without conflict. For example, "you can forgive and not forgive at the same time"

3. Allow for the opposite possibility when speaking about the way it was, or will be. You can say, "You'll either get better or you won't".

Finally, we agree with O'Hanlon and Beadle (1999) about how to learn their methods, they explain that the therapist can pick out some specific methods and give them a try, when these become automatic, go back and pick other methods.

## Similarities and Differences between Solution-Focused Therapy and Possibility Therapy

We are not the first ones to talk about the differences between the two models. In the interview conducted by Beyebach and Rodríguez-Arias (1991) after the book *In search of solutions* (O'Hanlon and Weiner-Davis, 1989) was published in Spain; O'Hanlon mentioned that he preferred to call his therapy as Solution-oriented instead of Solution-focused because his work is not only focused to find exceptions. In other words, in Solution-oriented therapy the direction is given toward solutions, it doesn't mean its focus is exclusively to identify exceptions; the therapist's task is more than that. In the same interview, Michele Weiner-Davis added, when focusing on identifying exceptions does not work the next step is focusing on some other aspects of the complaint pattern, although this does not mean quitting the orientation to solutions.

Something similar happens with Solution-focused therapy when the client does not report improvement or advance in a subsequent session. There are two possible procedures. First, an exercise of complaint deconstruction (de Shazer and Berg, 1991). The therapist can temporally deconstruct the interval between the sessions by using questions, and searching for exceptions and minor differences to amplify them and continue working on them. Second, creating doubt in what could be considered a rigid frame or construction of the problem in order to find the solution (de Shazer, 1988). In general terms, this process attempts to lead the client to produce different thoughts, feelings and behaviors. These interventions are very similar to the ones utilized in Solution-oriented therapy when discussing solutions is not working.

In 2001 O'Hanlon and Bertolino explained how throughout the years O'Hanlon heard students and professionals confirming his fears: the clients complained because their therapists were very positive and make them feel like their problems were minimized and their suffering was ignored. Thus, he put even more emphasis in acknowledging the client's experience while in Solution-focused the emphasis was on "solution talk". Possibility Therapy was born from this difference. It is based on resources and solutions, considers the present, the past, and the future, while Solution-focused therapy mainly focuses in the future of the client. O'Hanlon and Beadle (1999) explained why it is sometimes necessary to pay attention to the past. If the client is oriented to the past, it is important to guide the therapist's attention to the client's past, at least initially. If the therapist does not do that, the client is apt to feel misunderstood and invalidated and the therapy can slide to a screeching halt. Only after the client feels validated and supported is it possible to start opening avenues into the present and future. Validation is about supporting clients without judgment but it does not mean that therapist agrees with all clients' actions.

We think that in the earliest version of Solution-focused therapy, therapists paid little attention to client's feelings and they were more occupied asking about behavioral descriptions of client's goals and in therapy advances. An example was the Kiser's doctoral dissertation (Piercy, Lipchik and Kiser, 2000) which involved interviewing 13 of the founders of solution-focused therapy. He reported that one of his respondents said most of the founders of solution focused therapy did not see affect as a point of intervention, but as a by-product of cognitive processes. That was an important difference with O'Hanlon's works. However, Solution-focused therapists have started writing about their work with client's emotions. For example, Kiser, Piercy and Lipchik (1993), Lipchik (1999), Miller and de Shazer (2000) and Lipchick (2002) have discussed the usefulness of letting clients talk about their feelings as much as possible, using emphatic comments such as: "That might be very hard to do", "What other things do you feel because of that?" or "What does it mean for you to feel so discouraged?"

The second author of this paper believes that applying solution-focused therapy has been a successful method to facilitate change in his clients, for example, with clients who have no ability to talk about their feelings, emotions and their meaning (frequently with adolescents) he uses his personal emotions, feelings or personal histories explaining their similarities and how he solve them.

Trying to synthesize the differences, Gonzalez and Alfonso (2005) mentioned that the therapy model of de Shazer is based on the question: *How do we construct solutions?* While Bill O'Hanlon works currently with the question: *How do we open possibilities for our clients?*

How do we construct solutions in solution-focused therapy?: Solution-focused therapists start the therapy with the certainty, at least theoretical, that they will be able to build an expectation of change in the client. This is the main premise in the de Shazer's model: "Without the expectation that things can go better, the therapy does not make sense. In fact, the expectation that things can go better is the central premise of the whole therapy" (de Shazer, 1988).

That leads us to the question: How do Solution-focused therapists put into practice the theory of change? Through a cooperative therapeutic relationship, they attempt to build inside the client's therapeutic reality the idea that the change is *possible and unavoidable*. They start elaborating strategies to project the present in the most immediate future, a future without the problem. This transmits the idea that the therapist hopes to find changes and is sure these will happen.

How do we open possibilities for our clients in possibility therapy?: The first step in Possibility therapy is to let the clients know that they are heard and understood in their suffering, their concerns, their felt-experience and their points of view. Discussing what the client says is a form of acknowledgment but is only half of the job, the other half is to keep the possibilities opened; a way to do so is by using the language; for example, changing the present tense into the present perfect tense. Once the client says: *I fail at everything,* the therapist says: *So, you've failed at most of the things you've tried* (O'Hanlon and Beadle, 1999); by doing this the therapist introduces the possibility that change might happen in the future and the client may not fail at everything anymore.

Everything the therapist says or does can open a possibility. There isn't a solution; there are possibilities where the focus is to help the client. Also, as well as Solution-focused

therapy, it focuses on what is doing well and on how to move into the lives they want (O'Hanlon and Beadle, 1999).

## INTERVIEW WITH BILL O'HANLON

As the next aspect in this paper, we included the interview done to Bill O'Hanlon in the first phase of this work. Our comments were added after the interview, because it was done in a virtual way.

*Question (Q):* You might agree with us that there has been some confusion regarding your model, which you used to call "Solution-oriented therapy" and now call "Possibility Therapy", and de Shazer's "Solution-focused therapy". We believe that the time has come for shedding some light into this confusion. Why did you both use the same techniques (i.e., the *miracle question*, pre-treatment change, and scaling questions)? And, did you and de Shazer talk about those interventions and then began to use them in therapy?

*Bill O'Hanlon (BO):* I have never used The Miracle Question in my therapy. I have asked about pre-treatment change and occasionally used scaling, but not too much. The "miracle question" works when it works and doesn't when it doesn't. That is why I am not wedded to particular methods. I find these techniques antithetical to doing therapy. I have other ways to get to a similar place. I like to have a conversation that is oriented towards strengths, abilities, resources and solutions rather than have formulas and techniques dominate the therapy session. Steve de Shazer and I were both very influenced by Milton Erickson, who was oriented towards resources and viewed his patients as sources of solution. We created our approaches at about the same time (there is some question as to who created it first-I gave the first paper on the subject in 1983). In addition, my colleague and co-author Michele Weiner-Davis worked with the Milwaukee Brief Therapy group before we wrote our book together, so she brought that influence to the book.

So, to summarize and add a few more points about the difference that makes the difference:

1. The first difference is that Solution-oriented Therapy (now Possibility Therapy) has no fixed or set formulas or techniques, as opposed to the very formulaic approach of solution-focused therapy.

2. I changed the name of my approach to "Possibility Therapy," some years ago to avoid the confusion between the two approaches.

3. Another difference is that "Possibility Therapy" emphasizes listening to people's suffering and problem views more than Solution-focused Therapy. I think that acknowledgment of suffering is given short shift in the Solution-focused approach, leading to some client dissatisfaction and therapist frustration.

4. A final difference is that Steve de Shazer, in taking his very minimalist approach, which I admired, perhaps made his model too minimalist-leaving out political and social issues that can affect problem formation and problem resolution.

*Authors' comments:* Recently, some authors have pointed out the expanded role of emotions in SFBT (i.e., Pierce et al., 2000; Trepper et al., 2006). In our opinion, the role of emotions, cognitions, and actions in SFBT has become more balanced over the years (i.e., Miller et al., 2000). This balance was already an integral part of O'Hanlon's model, as demonstrated in his book (O'Hanlon and Weiner-Davis, 1989) and clinical training workshops. Moreover, O'Hanlon and Beadle (1999) also incorporated a fourth area where therapists and clients work collaborative to implement change, that is, the "context". This area is another difference between the two models, as O'Hanlon points out above. Because both models have evolved, we would like to invite therapists and students of therapy to not only read the earlier books and papers, but to pay attention to new editions and latest books and papers.

*Q:* We saw in your web page a lot of suggestions, a lot of questions we can use with our clients. Nevertheless they do not have an specific name. We know which techniques were developed by the de Shazer's group. Which techniques were specifically developed by you?

*BO:* I developed the methods of using language to create positive expectancy and to acknowledge suffering and problems while still inviting the client to discover strengths and possibilities. I also developed the use of stories in solution-based therapy. I articulated the orientation of present towards the future in this approach and set forth the basic premises in my early writings.

*Q:* Talking about the differences, it seems that the SFBT model does not pay enough attention to emotions, or validating the client's experience, and it leaves a short time for clients to speak about problem stories. We have witnessed a change towards a more balanced concern in the last few years. What is your opinion about this change in emphasis on emotions? Could this change reduce the differences between SFBT and your methods?

*BO:* Yes, I think it reduces some of the differences, but the main point I make is not about emotions per se, but about acknowledgment of any suffering, fears, concerns or problems. I think that is still underemphasized in the solution-focused approach.

For example, I am quite happy to discuss diagnosis with my clients and I think many solution-focused therapists would have a hard time doing so.

*Authors' comments:* The first author of this paper considers that one of the key elements in O'Hanlon's model is the emphasis on therapist's flexibility. That is, when the client needs to talk about suffering, fears, concerns or problems, the therapist has to do it, and talking about solutions and exceptions that might invalidate the client's experience. This opinion appears to be corroborated by Piercy et al (2000), who indicated that Solution-focused clinicians need to know how to acknowledge, join with, and respond to client emotions as well as thoughts and actions. The second author's view is different, since he believes that solution-focused therapists already do that. Also, some therapists have commented that clients can remain "stuck" with the problem until their concerns and experience were acknowledged

and validated. The notion of flexibility and collaboration are integral parts of O'Hanlon's model since its conception.

*Q:* In the book *In search of solutions* as well as in *Evolving possibilities* you have explained the premises of Solution-oriented therapy. Would you say these premises are the same, or very similar, to the premises of Solution-focused therapy? In other words, are we to understand that main difference is in the application of such premises, rather than premises themselves?

*BO:* Yes, I agree that the differences are mainly in the application rather than the premises. I also think I articulated those premises and they were borrowed from me by others, including de Shazer, so that accounts for many of the similarities.

*Q:* Do you believe that Solution-focused and Possibility therapy are similar because Erickson was such a strong and evident influence on you and de Shazer?

*BO:* Yes, I think so, but also they were both influenced by the MRI approach and by systemic therapies that were popular around the early 1980s, which of course were both influenced by Milton Erickson's work.

*Q:* We understand you apply the theoretical premises in different way. In other words, you focus not only on the search of exceptions and the projection to the future, but you also consider possibilities. Moreover, if the search of exceptions is not successful, you focus on the problem. That is, you explore the complaint pattern, the emotions and the feelings related to the problem; without ignoring solutions. We see all of these options as *possibilities* to find the solutions, because after that, the Possibility therapist continues on the solution path. . At this point, we stop understanding how it is done. How do you return to the way of solutions after validating the client's experiences, recognize his problem, etc.? Could it be through questions such as*: "So based on what you have told me so far, how will things be different when the miracle has happened? When things have been resolved?*

*BO:* As I mentioned above, I do it mainly through the use of expectancy language. Then when the client is ready to move to new possibilities and solutions, they signal that to me by using the same kind of language, that is, language that is mainly oriented towards solutions and possibilities rather than complaints and problems. Only then do I begin to lead more towards this direction.

*Authors' comments:* In our opinion, this is one of the basic differences between the two therapy models. While O'Hanlon seems to work "alongside" the client, the SFBT group appear to work "one step ahead", pointing out resources and solutions that the client may not be ready to acknowledge yet. We have been witness to what being steps ahead of clients can do: progress is halted, resistance comes up, and clients may not come back.

*Q:* We detect another difference between your method and SFBT. It's about *depathologizing* or *normalizing clients' situations* Here the question is: What are the criteria to use "*normalizing"?* When do you recommend using it?

*BO:* Normalizing is only one of many methods that can be used in Possibility Therapy, but I use it when the client has some idea that he or she or they are sick or crazy when actually what they are experiencing can fit within the range of typical human experience.

*Authors' comments:* As any tool in therapy, using normalizing with all clients can be a mistake. Caution should be used. We need to evaluate each case and use only those interventions that fit the client's problem.

*Q:* When you work on changing the viewing and doing of the problem, it sounds like a cognitive behavioral therapy (CBT) technique. It looks very similar to cognitive restructuring procedures. Also, some therapists have referred to Solution-focused therapy as a form of CBT. What are your thoughts about that? And, what do you think about it in terms of your methods?

*BO:* Well, there is some similarity, especially when I speak of changing the viewing and changing the doing. But there is a wide gap between these approaches, I think, in that CBT is oriented towards problems and deficits (the client/patient has disturbed or irrational thinking or views that need to be corrected by an expert therapist). Another difference is that, if I discovered that some irrational or distorted thinking was helping the person resolve their problem, I might encourage them to engage in such thinking more often. A cognitive therapist would be disturbed by this approach, I think.

*Authors' comments:* The fist author of this paper was trained as a cognitive behavioral therapist before learning about O'Hanlon's work. Not only does she find a lot of similarities among these two therapy model, but she agrees with O'Hanlon's comments about CBT being oriented towards problems and deficits. In her experience, integrating both models can be beneficial to clients.

*Q:* Well, we have read about collaborative therapy and we have the sense it might have been born out of working with people who were sexually abused. Are we on the right track? What are your thoughts about using this kind of therapy in other cases?

*BO:* Inclusive therapy, bringing in and valuing devalued aspects or the self and helping people and therapists make room for seeming opposites or polarities, was developed in the work with people who had been sexually abused. I have used the approach with many other people with many difference kinds of suffering, though. And have found it works well (except when it doesn't, of course).

*Q:* You have mentioned that the Solution-focused therapy became to be formulaic with an "official game of questions", that follows certain sequences; and these have little relationship with your intuitive and spontaneous method. That is true but it might also be very useful to have a scheme or formula. How do you conduct a session?

*BO:* No, I have no scheme or formula. I find I create a new approach for each person or couple or family or group. Each person and situation is different, so no scheme, structure or sequence would work for all.

*Q:* We know those are difficult questions because the answer could be without patterns, therefore maybe it is better to ask you about something like the *components of a Possibility therapy interviewing* (or Inclusive therapy if you prefer use this name now).

*BO:* Yes, perhaps there are some components. Here are two[3].

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[3] Here O'Hanlon mentioned the seven steps in possibility/solution-based therapy and the six main components of the possibility therapy included previously

*Q:* We are curious about the things that you do not do any more. For example, do you still use the question about "pre-treatment change" in therapy?

*BO:* Sometimes. Sometimes not.

*Q:* What kinds of things have you stopped doing in therapy? Things that you did in the early days of "Solution-oriented therapy" and you don't do or use anymore.

*BO:* I don't think I left things behind. Just added things and became more flexible.

*Q:* Finally, three short questions. You have described the development of therapy as "waves". As your friend Tapi Ahola said, the Third Wave was solution oriented. Do you think the work you currently do could be called the Fourth Wave? Does it have a name? Or is it maybe an evolution of solution oriented methods into a larger number of possibilities for change?

*BO:* Perhaps there is a "Fourth Wave". It is beyond method and technique. Scott Miller has been talking about how all therapies work about the same. The things that make a difference are the client's perceptions of the quality of the relationship with the therapist. This makes sense to me. And I think methods and theories do matter a bit. And the person and confidence and knowledge of the therapist make a difference too.

*Q:* Do you prefer to call your approach Possibility Therapy or Inclusive Therapy? If so, why?

*BO:* I only give it a name for marketing purposes and to talk about it easily with others. I am not sure other than that I care about the name.

*Q:* Do you have any information about meta-analysis or another empirical research focused on Possibility therapy or the "Fourth Wave"? Some of us like to look into research to evaluate the efficiency of therapy models. Do you have any information about results of this kind of research?

*BO:* Again, I would see some of Scott Miller's recent work, debunking the idea that techniques and theories are as important as we thought for many years. It appears that the personal and interpersonal and environmental resources of the client, as well as having a good human relationship between client and therapist, as well as instilling hope and positive expectancy, are the main sources of positive change in therapy. This has been researched quite a bit since the early 1970s (see Wampold's, "The Great Psychotherapeutic Debate").

## DISCUSSION

Whereas Solution-focused therapy has a plan or blueprint that can be superimposed to each session, Possibility therapy is dance where the therapist is in tune to the steps, movement, direction of the client. Each time, the dance is different, but the flexibility and collaboration between the dancing partners remain. There are many techniques in psychotherapy from different therapeutic approaches or theories that have things in common. It could be possible to talk about them almost as synonyms; for example, changing the viewing could be very close to cognitive restructuring by cognitive behavioral therapist, as we commented before; or stop doing as a synonym to negative reinforcement or extinction in behavior modification. Then, talking about similarities between Solution-focused therapy and Possibility therapy is as common as talking about similarities between systemic therapy and

cognitive behavioral therapist; but the relevancy of our paper is because the difficult for therapist in training to understand that SFBT and Possibility therapy can share theoretical premises and techniques but these born and grew up in different ways. We think that a therapist can use many techniques, but is better to have a dominant theory of reference, and then to integrate techniques from other therapeutic approaches.

Then, therapist could prefer O'Hanlon's approach or SFBT, but can use something from the other one. This could happen because those therapy approaches are oriented on solutions and share theoretical premises. Although in Possibility therapy there are more possibilities, it does not focus exclusively on searching exceptions.

One difference between O'Hanlon's approach and SFBT that we did not mention previously, is about the research from each approach. We realize that O'Hanlon teaches and writes about his approach and most of the people interested on it are therapist, people who are most worried by how apply it than in doing research about it. On the other hand, have been investigators interested in SFBT, and that is why there are a lot of papers about effectiveness of Solution-focused therapy. Using formulaic version of solution-focused therapy gives us the opportunity to replicate exactly the way to conduct therapy; because it gives us a scheme of the sessions. This has facilitated more than 20 years of research about its effectiveness. Also has facilitated that many therapists learn and practice the model. For example, after a revision; Estrada (2006) and Estrada, Beyebach and Herrero de Vega (2006) show recent data about the effectiveness of Solution-focused therapy (considering its briefness, changes permanency, different kind of problems). They analyzed the research of the last 20 years, in different countries and samples (included 13 follow up studies, 16 pre-post test studies, 4 experimental controlled studies and 4 studies with n=1 design). They concluded that outcome studies and especially the most controlled studies gave an important support about the effectiveness of the Solution-focused therapy, considering its briefness, changes permanency, different kind of problems (Estrada, 2006).

Considering most recently works published by solution focused therapists (de Shazer, Dolan and Korman, 2007; Lipchick , 2002; Miller and de Shazer, 2000) we can understand how they work on emotions, these approaches both kind of therapy. Afterward, in earliest works of solution focused therapy the differences with O'Hanlon's approach were bigger than now. Even though we consider Possibility therapy is more flexible, because it does not have schemes, it adapts to each client, it is an attitude of the therapist. Possibility therapy attempts to introduce flexibility into the theories and methods therapists have, as well as introducing possibilities in the client's life (O'Hanlon and Beadle, 1999).

Finally, we can insist that there are more similarities than differences between them and we think therapists should use all things they believe can work with their clients. And also, keep a record of it to facilitate others to learn about them.

## ACKNOWLEDGMENTS

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