

NARRATIVE AND SOLUTION-FOCUSED THERAPIES: A TWENTY-YEAR RETROSPECTIVE

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The Therapeutic Conversations (TC 1) Conference in Tulsa, Oklahoma in 1991 was a historic event in the advancement of postmodern therapies. We (David, a narrative therapist, and Jeff, a solution-focused therapist) were profoundly affected by this summit of the pioneering voices in narrative, solution-focused, strategic, and systemic therapy. This article highlights the evolution of both narrative and solution-focused therapy since TC 1 from our distinct, but overlapping vantage points. We have noted the increased differentiation of these approaches therapies since they were first compared (Chang & Phillips, 1993). While this differentiation is significant, we note that a hybrid of narrative and solution-focused therapy is being practiced among new practitioners, a development that may not have been predicted or hoped for by first and second-generation narrative and solution-focused therapists. This development is situated within the current climate of evidence-based practice, the recovery model of mental health, positive psychology, strength-based approaches, and the recent emphasis on resilience. Finally, we comment on the perils and possibilities of current developments and speculate as to what this might mean for the future of both approaches.

As I (JC) stated in my editor's introduction, the first Therapeutic Conversations conference in Tulsa (TC 1) was an inflection point in the culture of psychotherapy. Therapy became less about delivering pronouncements from behind the mirror, and more about conversational collaboration. In the years just before the conference, the therapeutic approach pioneered by Michael White and David Epston, not yet called narrative therapy (White, 1986a, 1986b, 1987), and the solution-focused (SF) approach (de Shazer, 1985, 1988, 1991) were becoming more popular. Jeff

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and his colleagues noticed some similarities, working at an adolescent treatment center, and subsequently described them (Chang & Phillips, 1993) in the TC 1 conference proceedings (Gilligan & Price, 1993). David was working in managed care and learning about postmodern therapies. He read Jeff and Michele's chapter with interest, still encourages students and supervisees to read it, and highlights it as a key part of his development as a postmodern therapist.

As young practitioners focused on technique, we glossed over the differences between the approaches, and likely made too much of the superficial similarities—as de Shazer (1993) suggested, a family resemblance akin to the similarity between apples and pineapples. In the last two decades, however, narrative and solution-focused therapies have differentiated themselves significantly. Some differences we noted 20 years ago (especially the micro/macro distinction) foreshadowed subsequent developments. Twenty years after TC 1, we think it is timely to re-contrast and re-compare narrative and solution-focused therapies. After describing commonalities, we describe key developments in the narrative and solution-focused therapies. Then, we describe their current status in relation to one another. We conclude by contextualizing these approaches in light of recent developments in the field of psychotherapy.¹

COMMONALITIES

Postmodern View of Language

Both narrative and solution-focused therapies eschew a modernist view of language, which presumes that language represents internal mental constructs. Instead, they operationalize a postmodern view of language, in which language constitutes social reality. As Shotter (1993, p. 20) observes, in a constitutive view of language, we “unknowingly ‘shape’ or ‘construct’ between ourselves . . . not only a sense of our identities, but also a sense of our ‘social worlds.’” Narrative and solution-focused therapists knowingly shape identities and social worlds through the interview process, but differ “about the most helpful way to steer . . . the conversation . . .” (Mills & Sprenkle, 1995, p. 369).

In keeping with the macro/micro distinction we made in the previous comparison (Chang & Phillips, 1993), solution-focused therapists steer the conversation toward hypothetical solutions, exceptions to the problem, and solution descriptions. Narrative therapists elicit descriptions of a client's agency in relation to the problem, and deconstruct the discourses that support the problem. While a respectful solution-focused therapist would not shut down conversations about larger cultural constructs, SFT would not go there by default. On the other hand,

¹We suggest reading the original comparison chapter. We have refrained from reviewing it in detail due to space constraints

a key focus of narrative therapy is examination of the effect of discourses, and clients' responses to them.

Nonpathologizing

The family resemblance that we first noticed over twenty years ago, namely that these approaches focus on what's going right (Chang & Phillips, 1993), leads both narrative and solution-focused therapists to position themselves outside of dominant pathologizing mental health discourse. Simply asking about problem-free times, exceptions, unique outcomes, and how clients distance themselves from oppressive cultural stories bypasses pathology. White (1996, personal communication) suggested that we are "swimming in a sea of disrespect" of typical mental health practices, and that both SFT and narrative offer a corrective. Both approaches sidestep conversations about pathology in similar linguistic forms, but with different intent.

DEVELOPMENTS IN THE NARRATIVE COMMUNITY

Power, Gender, Race, Class, and Culture

By the early 1990s, narrative therapy clearly focused on societal issues. Over the past two decades, Michael White's practice incorporated his analysis of power relations, gender, race, class, and sexuality. It was catalyzed by his close relationship with the Just Therapy Team (Waldegrave, 1990) of New Zealand, which has incorporated culture, gender, class, and economics into their work, eroding the distinction between clinical work and social advocacy.

Others, particularly women who have woven feminist discourse in their therapeutic work, have followed suit. Johnella Bird (2000), for example, explicitly addresses the power differential between the therapist and the client. Her thoughtful use of language in therapy developed into "relational externalizing." In contrast to traditional externalizing, which refers to the problem as having a life of its own that must be defeated, relational externalizing invites clients to mindfully examine their connection to the problem. Traditional externalizing conversations, that encourage opposing or defeating the problem, are viewed as a relic of masculinist discourse that can reify a binary—win/lose or control or be controlled. Bird challenges this masculinist language, encouraging the client to revise her or his relationship to the problem, eroding the binary, and examining the discursive context of the problem. Relational externalizing is but one example of the feminist relational approach to language, self, and therapy. Others (e.g., Weingarten, 1995) have also nudged narrative therapy toward a more nuanced, feminist-relational stance, particularly with problems typically seen as gender-related: supporting those who have been sexually assaulted (Yuen & White, 2002); challenging homo- and transphobia (Tilsen & Nylund, 2010); helping women to overcome eating disorders (Maisel, Epston, & Borden, 2004); and attending to gender and power with couples (Freedman & Combs, 2002).

Applications to Specific Problems

In addition to its focus on gender, in the last two decades, applications of narrative therapy to specific problems, populations, and modalities have proliferated: anxiety disorders (Headman, 2002), attention deficit hyperactivity disorder (Nylund, 2000), child protection concerns (Madsen, 2007), group therapy (Weber, Davis, & McPhie, 2006), intimate partner violence (Beres & Nichols, 2010), mediation (Winslade & Monk, 2000), school problems (Winslade & Monk, 2007), seniors (Osis & Stout, 2001), substance misuse (Gardner & Poole, 2009), trauma (Denborough, 2008), and young offenders (Tahir, 2005), to name but a few.

Interdisciplinary Cross-Germination

Furthermore, narrative therapy's maturation has opened dialogue with many disciplines informed by postmodern and poststructuralist ideas, including anthropology, the arts, cultural studies, ethnic studies, literary theory, philosophy, and queer studies. These connections have further distanced narrative therapy from the ideological tenets of psychology. In fact, McLeod (1997) has described narrative therapy as the only post-psychological therapy. Narrative therapists continue to cultivate rich relationships with other bodies of thought: Adlerian therapy (Disque & Bitter, 1998), the contemplative tradition (Blanton, 2007), existentialism (Richert, 2010), hermeneutic philosophy (Huntington, 2001), and neurobiology (Beaudoin & Zimmerman, 2011), to name but a few.

Community Work

One of the most exciting developments over the past 20 years is the emergence of narrative approaches toward community work. Recognizing that individual or family therapy provides incomplete solutions for problems requiring community change, Cheryl White and David Denborough, among others, have led the way developing culturally appropriate ways of responding to individual, family, community, and historical trauma (Denborough, 2008). Their efforts, and others', helped erode the artificial distinction between micro and macro practice, a historical tension in social work, which defined social workers as either clinicians or community development workers. To reflect the seamlessness of community and clinical practice, the *International Journal of Narrative Therapy* was renamed the *International Journal of Narrative Therapy and Community Work*.

Conceptual Frames for Practice

Three particular conceptual frames for practice are worthy of mention. Winslade (2009) has been operationalizing the ideas of French poststructuralist Gilles Deleuze. Deleuze follows the general tone of Foucault's critique of modernity. Like Foucault, his central concern is with how modern power operates on a micro level

through normalizing discourses that permeate all aspects of social reality and everyday life. There are slight differences between Foucault and Deleuze and their analysis of modern power; Deleuze focuses much more on desire. Foucault's emphasis is on the disciplinary technologies of modernity and the targeting of the body within regimes of power/knowledge. Deleuze's attention is on the colonization of desire by various modern discourse and institutions. Winslade uses Deleuze's concept of "lines of flight"—"shifts in the trajectory of a narrative that escape a [constraining] line of force [desire] or power" (p. 337). Narrative therapy can therefore be seen as the process of developing new lines of flight.

Secondly, White (2007), in his final book before his death, utilizes Vygotsky's "zone of proximal development"—the difference between what a learner can do without help and what he or she can do with help—to create a map for narrative practice. Vygotsky's social developmental theory invited White to think of therapy as a series of scaffolding conversations—bridging a client's zone of proximal development to enact a new response to the problem.

Third is the concept of the absent but implicit (Carey, Walther, & Russell, 2009). White suggested that experience is multilayered—there are both explicit and implicit layers. For clients, the explicit is typically their experience of the problem. Conversely, the implicit—preferences, values, hopes, intentions, and dreams—have unspoken meaning, providing a contrasting background to the problem. White provided a map for scaffolding conversations to elicit the absent but implicit, aspects of client identity and experience that lie beyond the problem story.

Reflecting Team, Outsider Witnessing, and Definitional Ceremony Practices

The practice of having an observing team exchange physical locations with the client and therapist to offer reflections, and exchange places again for the therapist and client to discuss the team's reflections, initially known as the reflecting team (RT), was originated by Tom Andersen (1987). Andersen, influenced by social constructionist and hermeneutic ideas, would not have identified himself as a narrative therapist. While RTs have been adopted by practitioners of diverse theoretical orientations, the plurality of published accounts are by narrative therapists (see Chang, 2010a, for a comprehensive review). White (2000) commented:

Although there are similarities in the structure of the reflecting-team work that is practiced from place to place, [there is] no uniform approach . . . [or] consensus [about] the mechanism at work . . . in relation to its frequently transformative effects. (p. 71)

Along the same lines, Jeff has suggested that the RT is "a technique in search of a theory" (Chang, 2010a, p. 39). Nonetheless, we agree that the RT is now best known as a narrative practice.

The RT format has lent itself to a conceptual framing as definitional ceremony as proposed by Myerhoff (1986). As therapeutic practice (Carey & Russell, 2003),

definitional ceremonies viewed by outsider witness groups are intended to refashion identity in a public and communal, as opposed to a private and individual, way. They consist of a “multi-layered tellings of the stories of people’s lives” (White, 2005, p. 15), usually structured as a telling by the therapist and client, a retelling of tellings by the team, and a retelling of retellings by the therapist and client.

Narrative Therapy and Evidence-Based Practice

In 2001, we presented together at the Pan-Pacific Brief Psychotherapy Conference in Osaka, Japan, highlighting the similarities and differences in our approaches (Nylund & Chang, 2001). Our discussant, the former president of the Japan Behavior Therapy Society, asked our positions on evidence-based practice (EBP). David replied:

I believe in evidence, but I am more interested in what constitutes evidence, and who gets to decide what counts as evidence. Is it professionals, licensing boards, researchers, and journal editors? Or is it clients? If a young person is able to reclaim his life from ADHD, for example, and we create and circulate a therapeutic letter about his experience, I consider that just as compelling as a randomized clinical trial.

Jeff was left wishing he had said something as insightful.

This exchange reflects a key dilemma for narrative therapists—the predominantly North American need for empirical support for therapy, versus narrative therapists’ historical opposition to the empirical approaches that quantify lived experience, specify normality, and dis-member persons. Depending on one’s perspective, narrative therapy has been slow to come to the EBP table, or has put up principled resistance to the pressure to sell out.

Notwithstanding this double bind, there is a developing kernel of empirical support for narrative therapy. Vromans and Schweitzer’s (2011) study of major depressive disorder and Besa’s (1994) research on parent-child conflict, are two examples. Whether engaging in quantitative research amounts to surrendering key values, or is a viable strategy to earn a seat at the evidence-based table, we believe it is not sufficient for the narrative community to throw out the evidence-based baby with the ideological bathwater (see Parker, 2004). Instead, postmodern therapists and researchers must tackle the need for empirical support on its own terms (see Strong & Gale, 2013), while continuing to critique logical-positivist science.

In the post-Michael White era, narrative therapy is rapidly growing in many areas of the globe. Therapists and graduate students are thirsty for narrative therapy training in spite (or because) of the trend in psychotherapy towards pathologizing practices. Most graduate programs include narrative therapy in their curricula and many agencies have incorporated narrative ideas in their work. Two decades later, narrative therapy is vital and evolving.

DEVELOPMENTS IN THE SOLUTION-FOCUSED COMMUNITY

Solution-Building Orientation

Solution-focused ideas have been applied to a myriad of populations and clinical problems (see Connie & Metcalf, 2009; de Jong & Berg, 2008; Miller, Hubble, & Duncan, 1996; Nelson & Thomas, 2007; Pichot & Dolan, 2003 for illustrations of the breadth of applications). However, in our view, the most crucial development has been the clear shift to a solution-building orientation. By 1988, de Shazer and colleagues were distinguishing SFT from the brief strategic model (Watzlawick, Weakland, & Fisch, 1974). Rather than seeking to develop solutions based on problem characteristics (de Shazer, 1985), de Shazer (1988) and colleagues had concluded that it is not necessary to know anything about a problem to build solutions. How clients described exceptions (presence or absence; random or intentional) came to be much more important than anything to do with the problem itself. This assumption underlay all de Shazer's subsequent writing, as he expanded his exploration of how language operates in therapy, primarily via the influence of continental philosopher Ludwig Wittgenstein.

Wittgenstein as Intellectual Foundation

From around the time of TC 1 until his death, de Shazer connected his work with Wittgenstein's (de Shazer, 1991, 1994; de Shazer et al., 2007). De Shazer maintained "that SFBT is a practice or activity that is without an underlying (grand) theory" (de Shazer et al., 2007, p. 101). Wittgenstein asserted that "[t]he classifications made by philosophers and psychologists are like those who would try to classify clouds by their shape" (Wittgenstein, 1953, p. 154). He instead suggests that it is more useful to simply observe how language is used in everyday life. Similarly, de Shazer observes that theories of psychotherapy "[tell] us how things must be or should be rather than . . . describing how things are. Describing and teaching SFBT . . . demands that we focus on how things are. . . ." (de Shazer et al., 2007, p. 167).

Wittgenstein holds that the meaning of words is not inherent, but resides in the context of their everyday use—the "language games" in which we engage. Doing therapy is one particular language game. Within a game, the same word can have different meanings. Take, for example, the word game itself. While games of basketball, poker, solitaire, and peak-a-boo have some similarities, they have more differences, and the word "game" is used to signify them all (de Shazer, 1991). Despite their differences, through what Wittgenstein calls a family resemblance, we recognize them all as games. Furthermore, in one's private world, "inner processes [are] hidden from view, cannot be known, even by oneself, outside of the public and social context in which they arise" (de Shazer et al., 2007, p. 145). This is known as the private language proposition.

Wittgenstein has several implications for therapeutic practice. Wittgenstein's private language argument supports therapeutic practices such as scaling ques-

tions and relationship questions, which connect private experiences to the home base (de Shazer et al., 2007, p. 146) of everyday life. Furthermore, the opacity of personal experience blurs the distinction between affect, behavior, and cognition, since private experience can only be understood via external signifiers. And so the common idea that affect or cognition somehow propel behavior gives way to the belief that strands of experience cannot be disentwined. Accordingly, questions in SFT are used to elicit external signifiers of internal experience—usually descriptions of what the client wants, or when solutions are occurring. Contrary to the claim that SFT ignores emotion (Lipchik, 1999), de Shazer would assert that SFT views emotions not as something that drives behavior, but as part of clients' experience that can only be clarified by discussing external signifiers.

Minimalism

De Shazer (personal communication, 1992) known as “the man with Ockham’s razor,” stated that brief therapy lasts “as long as it takes to solve the problem and not one session longer.” The Brief Therapy Practice of London, England (BRIEF) has striven to push the limits of minimalism in therapeutic practice. As Iveson stated recently, their efforts to be brief are in the spirit of “. . . Steve de Shazer’s idea of constantly looking to see what’s necessary. What seems necessary at one point may not seem necessary later on” (McKergow & Glass, 2008, p. 126). For example, about the need to assign homework tasks, the BRIEF team found:

. . . it didn’t seem to matter if people did their tasks or not. So we stopped giving tasks. Actually this added something to the interview—we didn’t have to be thinking about what task to give, so we had more scope to listen to the client. If you watch . . . de Shazer’s interviews you will see a time when he starts thinking about the task. . . . So when you are not having to think about tasks, you can listen for other things, like preferred future descriptions. . . . (McKergow & Glass, 2008, p. 126)

Iveson describes another innovation to make therapy briefer yet:

We have worked very hard at trying to take away our intentionality—to be neutral about what our clients do. . . . So we stick with getting descriptions of what things would look like if. . . . Not . . . concerned about how they might actually happen. Stopping trying to help them get from A to B and focusing on describing A and B—where you want to get to and what you’ve already done without any hint about what you need to do about it. This has contributed to a reduction in our average number of sessions. (p. 126)

Movement Toward Empirically Supported Status

The SF community has made strides toward empirically supported status on three fronts. First, both the Solution-Focused Brief Therapy Association (Trepper et al., 2012) and the European Brief Therapy Association (Beyerbach, 2000) have developed standardized treatment manuals. Secondly, measures have been developed to

measure treatment fidelity (Lehmann & Patton, 2012) and solution behavior (Smock 2012), and other measures of solution behavior have been reviewed (Smock, McCollum, & Stevenson, 2010). Third, many well-controlled outcome studies are now available (see Franklin, Trepper, Gingerich, & McCollum, 2012). The accumulation of empirical literature on SFT has permitted two meta-analyses (Kim, 2008; Stams, Dekovic, Buist, & de Vries, 2006), both of which indicate that SFT is as effective as other treatments, with the potential advantage of being briefer (Stams, Dekovic, Buist, & de Vries, 2006). The US Office of Juvenile Justice and Delinquency Prevention designated SFT as a promising intervention for the prevention of school drop-out (Kim, Smock, Trepper, McCollum, & Franklin, 2010).

Microanalysis of Conversation

Recently, solution-focused therapists become attracted to the qualitative research methodology pioneered by Janet Beavin Bavelas at the University of Victoria (Canada), which focuses on moment-by-moment verbal and nonverbal communication (Tomori & Bavelas, 2007). This approach to research describes the effect of specific verbal strategies in shaping the therapeutic conversation, and whether the effect is consistent or discrepant with the therapist's espoused intent. Such conversation analysis, coupled with outcome research, can potentially improve the viability and quality of solution-focused practice.

Common Factors

Although the common factors of effective therapy are well-known (Duncan, Miller, & Sparks, 2004), the best known recent proponents of the common factors approach, Scott Miller and Barry Duncan, have roots in SFT (Berg & Miller, 1992; Miller, Hubble, & Duncan, 1996). Distancing themselves from SFT (Duncan, Miller, & Hubble, 1997), they and their colleagues have called the field to attend to what works across models. We have both incorporated much of the common factors thinking into our work. I (JC) can't help but think that my SFT training rendered me more open to this influence. Solution-focused therapists listen for pre- or extratherapeutic change, and therefore utilize instances of change unconnected with therapy. SFT has a simple way to attend to clients' motivation for tasks, a key part of the working alliance—the conceptualizations of visiting, complaining, and customer relationship patterns. Eliciting what clients want, and what they are already doing to get what they want, is likely to call forth hope and positive expectation. Because SF techniques (mainly questions) respond to client realities, desire, and solutions, not what therapists think they should do, SF techniques are less likely to be rejected by the client. Competent SF therapists may be better able to potentiate the common factors than those who conceptualize pathology from a specific theory of human functioning—SF therapists have less to unlearn. We suggest that their immersion

in SFT went a long way toward creating a context for the later developments in Miller's and Duncan's thinking.

CURRENT STATUS

Both solution-focused and narrative therapies have evolved considerably since they were first systematically compared (Chang & Phillips, 1993). We have both maintained connections in the narrative and solution-focused communities, as scholar-practitioner faculty in social work (DN) and counselling psychology (JC). From multiple vantage points, we suggest these approaches are both less differentiated from one another within our respective disciplines, and more differentiated from one another when viewed from each community.

Less Differentiation

In the past 20 years, narrative and solution-focused therapies have become a regular part of graduate curriculum in social work, marriage and family therapy, counselling, and psychology, becoming mainstream and losing much of their outsider status. Jeff developed and delivered the first graduate credit courses in narrative and solution-focused therapies in Canada in the mid-1990s. Counselling theory textbooks have tended to aggregated them as postmodern approaches. While they share a postmodern view of language, lumping them together obscures some important theoretical and procedural differences.

While pathology-based thinking dominates psychotherapy education, alternative philosophies, like the Recovery Model, the strengths perspective, the current focus on resilience, and Positive Psychology, which emphasize client resources and solutions, have emerged. Some have suggested that these approaches bear some similarity to narrative and solution-focused approaches (Caslor & Cyr, 2011). The mental health Recovery Model is an outgrowth of the recovery movement, a grassroots initiative that aims to place primary control of care in the hands of mental health consumers (Jacobson & Greenley, 2001). More a philosophy than an approach, the Recovery Model focuses on strengths and empowerment, and easily accommodates narrative and solution-focused values of focusing on positive changes, empowerment, non-expertise, collaboration, and hope. The strengths perspective is gaining a foothold in social work education (Saleebey, 2003). It is founded on: fostering hope based on historical successes; harnessing clients' resources; reducing stigmatizing language; and flattening the hierarchy between the client and therapist. Resilience literature describes factors that protect, or at least mitigate, the effects of adverse influences on individuals and families (Walsh, 1996). Positive Psychology is "is the scientific study of well-being, of what allows individuals and communities live fully" (Tarragona, 2010). Rather than focusing on

pathology and dysfunction, positive psychology emphasizes optimal experience, happiness, resilience, personal strengths, goals, and values, focusing on three central concerns: positive emotions, positive individual traits, and positive institutions (Positive Psychology Center, 2007). While originating from different intellectual traditions, these four approaches seem able to accommodate therapeutic practices from solution-focused and narrative therapies. On the other hand, both White and de Shazer disavowed the idea that they are looking for strengths that reside within an individual, for this would logically require us to locate deficits within individuals as well (Bannink, 2010; Chang et al., 2013). Although we are heartened by this trend of focusing on adaptive behaviors and strengths, we suggest that conflating these traditions under the strength-focused banner can result in poorly articulated practice, and that important distinctives of the solution-focused and narrative approaches may be obscured.

More Differentiation

Conversely, from within the narrative and solution-focused communities, these therapies are more differentiated than 20 years ago. At TC 1, these approaches were still relatively new. Narrative therapy had only been labeled as such the year before (White & Epston, 1990). Two decades of theoretical and clinical development have clarified the differences. While we (Chang & Phillips, 1993) overinterpreted the similarities in questioning practices as reflecting theoretical similarity, we now see the practice of deconstruction—the process of uncovering the cultural patterns that maintain problems—as a central technical and theoretical difference. While solution-focused therapists would not object to a discussion about these issues, they would be unlikely to initiate them (Chang et al., 2013). The use of deconstruction questions is emblematic of the broader cultural and social justice emphasis of the narrative approach—the macro side of the micro/macro distinction.

Both of us have heard some second generation teachers of narrative and solution-focused approaches suggest that their respective orientations should be kept pure. In their obligation to preserve a tradition, they believe it is necessary to keep these models from being contaminated. From David's perspective as a cultural studies scholar (Nylund, 2007), and Jeff's vantage point as a hermeneutic researcher (Chang, 2010b), this makes no sense for several reasons. First, ignoring cultural and contextual influences on our approaches to therapy keeps them frozen in time. It reminds Jeff a bit of being asked to evaluate whether Chinese food from a particular restaurant is authentic, as if authenticity is inherent to the particular dish. Secondly, it ignores the fact that neither White nor de Shazer's thinking remained static (Miller & de Shazer, 1998). Third, purity implies orthodoxy, which, we infer, would be antithetical to the thinking of both White and de Shazer. Orthodoxy invites unfortunate efforts to regulate or police the use of ideas and practices. Finally, the press to keep an approach pure ignores the frank reality that most therapists, over the course of their careers, simply do not work that way. Seasoned practitioners

broaden their theoretical influences and even incorporate ideas from outside of psychotherapy (e.g., art, music, philosophy, theater, and literature) to inform their work (Skovholt & Rønnestad, 1995). Moreover, the common factors literature (Duncan et al., 2004) suggests that experienced practitioners from different theoretical orientations work more similarly than experienced and novice practitioners espousing the same orientation.

Perhaps a position of theoretical purity is an effective vehicle for novice counselors to learn the theory and procedure of a particular model of therapy, as long as they see their chosen model as pragmatically useful, rather than exclusively true (Amundson, 1996). Furthermore, the field needs some innovators and practitioners to position themselves as purists to pilot new therapeutic practices and test the limits of their models. They may be a bit like code monkeys who know all the complexities of the program they wrote, while the rest of us simply use the software. Without some innovators, we stand to lose sight of the richness and complexity of the theory and history of the narrative and solution-focused approaches.

CONCLUSION

From a hermeneutic perspective, we began writing this paper over 20 years ago, when, driven by technique as young therapists are, we noticed some interesting similarities in these approaches. Two decades later, we have a different, more complex interpretive position. We have highlighted some of the developments we have observed, and described how SFT and narrative therapy have influenced, and been influenced by trends in psychotherapy such as common factors, EBP, and a proliferation of approaches that focus on the positive.

I (DN) recently taught a graduate family therapy seminar surveying theoretical models such as strategic, structural, Bowenian, cognitive-behavioral (CBT), functional family therapy (FFT), Milan systemic, solution-focused, and narrative therapy. The final assignment required students to choose a model and apply it to a case vignette. Half the class selected solution-focused therapy, while the other picked narrative. Many wanted to combine narrative and solution-focused therapy in their final project. I was surprised that no one chose the other models covered in the class. I assumed that some would decide on CBT or FFT given their current status as evidence based, or opt for one of more traditional approaches such as strategic or systemic.

This illustrates the ascendance, legitimacy, popularity, and mainstreaming of solution-focused and narrative therapy. Both models continue to grow and develop prolifically, albeit divergently. Conversely, while the models are taking different paths, many practitioners are combining (or muddling?) the two under the larger umbrella of strength-based and collaborative perspectives—a hybridization of postmodern therapies. Hence, narrative and solution-focused therapy are taking on a life of their own, perhaps different than their developers intended. Only

time will tell what course solution-focused and narrative therapy will take. To be continued . . .

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