An Integration of Adlerian Theory with Marriage and Family Therapy in a Postmodern World.

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Because of social constructionism, here is my thanks to those who have influenced my personal and professional development related to the meanings in this writing.

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Abstract

Alfred Adler was ahead of his time in offering a systems approach to individual psychology. With a look at the postmodernism’s impact on the field of marriage and family therapy, this author proposes that therapists must not forget the important developments during earlier years of psychology that influenced the development of postmodern ideas shaping marriage and family therapy. This author describes an integration of Adlerian ideas in a postmodern world of marriage and family therapy. In addition, a close look at outcome research representing one postmodern therapeutic modality – solution-focused therapy – provides a helpful story for the effectiveness of postmodern approaches in practice. Intentional integration of timeless theories can provide positive movement for individuals, couples, families, and greater cultural systems.
An Integration of Adlerian Theory with Marriage and Family Therapy in a Postmodern World.

The paradigm shift that postmodern thought has brought to our culture has greatly influenced the field of marriage and family therapy. To be effective professionals, it is necessary for Adlerian therapists in the postmodern times to wrestle with the differing paradigms in order to stretch self-awareness, and inevitably strengthen professional practice. The three frameworks presented here, are the timeframes of philosophical thought and cultural development that aided the progress of the current state of marriage and family therapy: the traditional framework (1890 – 1950), the modern framework (1950-1980), and the postmodern framework (1980-present).

The traditional framework begins with the development of psychology and extends through the Second World War. The modern framework begins just after the Second World War - when problem focused therapies emerged (O’Hanlon, 1994). The modern framework extends through the 1970s as Postmodern thinking began to be applied. Postmodernism arose in the 1960s (Pocock, 1995), but extended more visibly into the therapeutic practice during the 1980s (O’Hanlon, 1994). There is most definitely overlap in these timeframes and they are up for debate. Nevertheless, for the purposes of this writing, to give a common reference to the development of psychological thought, these dates will be used.

The Individual Psychology of Alfred Adler has contributed greatly to many therapeutic approaches across these frameworks but can be best understood and applied in the postmodern framework. A review of the philosophical and cultural developments of these frameworks will give a context for the expansion of Adlerian Individual Psychology in the midst of the evolution of marriage and family therapy. A close look at the effectiveness of two main postmodern techniques – solution-focused therapy and narrative therapy – will provide a basis for how postmodern ideas are applied and help create movement in peoples’ lives. A literature review of
outcome research on solution-focused therapy presents current scientific evidence provided by research. This comprehensive look at Adlerian ideas across three frameworks will help Adlerian therapists in the postmodern world articulate a theoretical position and intentionally integrate Individual Psychology with modern and postmodern ideas for effective practice.

Marriage and Family Therapy: A History of Developing Frameworks

The three unique frameworks provide context for the development of marriage and family therapy. They are distinctly different in what they have each contributed to the field. Though the frameworks seem contradictory at times, each paradigm has provided important shifts in thinking that have affected theoretical components of effective therapeutic practice. Often time’s paradigm-shifts can cause people to become overzealous about the new way of thinking and “throw the baby out with the bath water” by rejecting the helpful meanings found within the previous way of thinking. Each framework contributed meaningful elements of thinking for learning about human behavior and psychological processing and change. Therapists in the postmodern times must wrestle through these meaningful contributions and integrate ideas in helpful ways for intentional, effective, self-aware practice.

By first briefly identifying the contributions of older frameworks, this writing will examine the impact of the postmodern framework on the field of marriage and family therapy and argue that Alfred Adler was ahead of his time; he was a postmodern thinker whose theory reflects the best ideas of each framework. Outcome research of one particular postmodern therapy, Solution-focused therapy, will be examined and finally a discussion of how postmodern Adlerian practitioners can more effectively utilize postmodern techniques in ways that simultaneously honor the theoretical developments of previously developed frameworks will be presented.
The Traditional Framework

For this writing the traditional framework, also, known as the “First Wave” of psychology, (O’Hanlon, 1995) will be considered to have been most relevant during the following timeframe: the birth of psychology (considered by most as around 1880) and extending into the mid 1900s and into the height of the modern times. It is important to have a brief understanding of the previous Western philosophical movements led up to the conception of psychology, which originally extended as a branch of philosophy.

After a long period of tradition, superstition, irrationality, and tyranny of the Middle Ages, the Enlightenment thinkers looked to their primary authority: reason. The causes of mental illness moved away from witchcraft and demonic possession. Like the enlightenment, science and reason characterized the philosophy of the traditional framework and extended as important elements into the modern framework.

During the late 18th century Romanticism attempted to combine formality of rationalism from the past, with a more organic and emotional sense of the world. During this time, practical consequences and real effects of situations were important in knowing the truth; positivistic thinking was highly valued. Positivism is a philosophy, which asserts that the only real knowledge is scientific knowledge, which is discovered by using the scientific method. Positivism was a popularly held notion in the traditional and modern times.

Other concepts such as logical empiricism and rationalism became leading ideas that sprouted up during the traditional framework. Rationalism is that reason, not simply observation, is a source for knowledge. From this perspective, criterion for truth is intellectual and deductive rather than sensory. Pragmatism holds to the idea that if a worldview just explains physical nature and is not practical in explaining how meaning, values and intentions interact with the
physical world, it is a flawed philosophy. Pragmatism would ask, “is this idea practical”. One can see pragmatism as a concept also highly valued during the third framework of postmodernism. These philosophical developments influenced the theoretical and epistemological developments impacting the enhancement of marriage and family therapy.

The theoretical underpinnings of psychology during the traditional timeframe were focused on the unconscious. Anything considered abnormal was labeled as sickness. The field of psychiatry was more relevant than the field of psychology during this timeframe; and marriage and family therapy did not exist as a field of practice. Based on the individual psyche, the beginning of psychology shifted from the biological model, provided by psychiatry, to a psychological model. This allowed for new sets of questions about the affect of the mind on ones functioning, rather than simply the body.

**Key theoretical components.** During the traditional framework not only did epistemological ideas grow but other questions such as “how do people remember knowledge?” and “how do we learn?” became relevant. These questions inspired people toward psychology. Largely regarded as a branch of philosophy, psychology more formally began in 1879, when Wilhelm Wundt, started a laboratory to study psychology (Wilhelm, 2008).

During the traditional framework, (1980-1950s) major icons of the field of psychology were Freud, Jung, Adler, and Pavlov. Freud laid the foundation for psychotherapy, which formed based on psychodynamic theory and biological psychiatry. Therefore, psychotherapy at that time focused on pathology; pathology was found in the individual.

Moving away from philosophy of Romanticism, the first wave of psychology did not view abnormal people as morally deficient but developed the Diagnostic and Statistical Manual to describe human problems (O’Hanlon, 1994). Though these labels produced stigmas about
people who had mental illness, they also allowed professionals to have common language to communicate about abnormalities that people displayed. This authoritative, biologically based coding was filled with social prejudices and guesses that were presented as absolute truths. The original DSM was a best guess and a socially accepted way to measure sick vs. healthy, normal vs. abnormal. In context of this bio-psycho model, the typical therapeutic relationship was clinical by nature. By the 1930s, prescription drugs, electroconvulsive therapy, and surgery were additional methods of treating mental illness (Mental, 2008).

*The therapeutic relationship.* The primary focus of the first wave psychology was on psychodynamic theory, mental illness, the unconscious mind, and patient resistance. Because of the emphases on patient resistance, the therapeutic relationship was characterized by outsmarting the patient’s unconscious. The therapist was to act as a “blank-screen” and allow for very little self-disclosure. By not self-disclosing, the therapist would be like a screen where the client could project his or her feelings, associated with significant relationships of the past, onto the therapist (Corey, 2005).

Part of the transferring relationship in therapy was set up by the physical proximity: the client lying on a couch with their eyes closed helped the process of free association by removing a physical picture of the therapist from the client’s mind. The typical psychoanalytic therapeutic relationship was a hierarchy in which the therapist was the expert at analyzing the unconscious of the client, often referred to as a patient.

*Key techniques.* Psychoanalytic therapy, originated by Sigmund Freud, was the first philosophical and clinical approach to understanding human problems and change (Corey, 2005). This novel psychological theory was based on the ideas of personality development, the ID, ego, superego, and the unconscious. Psychoanalysis is a long-term therapy. When put into practice,
this therapy aimed to identify defense mechanisms – unconscious coping mechanisms that help one manage anxiety – and bring these defenses to the consciousness of the client.

A client in psychoanalytic therapy often seeks answers to the ‘why’ questions that he or she has about life. This is dramatically different from post-modern approaches that rather than ask ‘why’ would ask ‘what meaning do you make of it’ and ‘what do you want to do about it’? Freud’s psychoanalytic therapy was the basis for psychology in its sprouting years as a field of study and a profession of practice. In addition to Freud’s psychoanalytic therapy, Alfred Adler contributed a timeless theory of individual psychology to the traditional framework.

Adlerian psychology and the traditional framework. Adler himself was a lead figure during the foundations of psychology. He joined Freud, Jung and others in Vienna who initially worked closely together developing psychological theory. Freud however, had very little tolerance for his colleagues who disagreed with his doctrines. After many disagreements about theoretical and clinical topics, Alfred Adler founded his own therapeutic school and articulated his own psychology, known as Individual Psychology.

Adler’s individual psychology was based on less traditional ideas; instead, his ideas reflected that of what we refer to today as postmodernism. Some basic assertions of Individual Psychology were that humans have a subjective view of reality, unique ways of viewing their world and that humans could only be fully understood within their context and by viewing them in a holistic way (Corey, 2005). During the traditional period, psychotherapy was practiced on individuals but Adler was not afraid to explore unchartered territory of working with families.

Alfred Adler was the first practitioner to conduct public demonstrations with families (Corey, 2005; Dinkmeyer & Dinkmeyer, 1981). He did this for purposes of educating people in the community. Adler believed and taught that siblings had a greater impact on personality
development than the mother. This was significantly different from Freud’s ideas about the
mother’s impact on personality development. Adler offered a view of individuals themselves as
systems within larger systems of family and society.

Adler founded clinics, conducted live presentations and educated public school teachers,
social workers, physicians and other professionals. He implemented a community wide approach
and was not shy about exposing his practice. Adler’s Individual Psychology was not simply
biologically or psychologically based, it was more holistic: biological, psychological,
sociological, and cultural in nature. This collaboration of viewing the individual from different
facets provided a holistic way to view sustainable change for human relationships.

Though Adler’s Individual Psychology arose during the traditional framework, Adlerian
ideas could be better understood within a postmodern context, which would develop almost one-
hundred years later. This occurred thirty years after Adler’s death. Though Alfred Adler passed
away in 1937, his contributions to psychology would permeate the development of many new
theories in the modern era and positively influence not only marriage and family therapy, but
also education systems, social work practices, and medical practices. A closer understanding of
the modern framework would trace Adler’s ideas through to postmodern times.

The Modern Framework

The modern era, also known as the progressive era was a time of great advancements that
affected all facets of culture especially the life style of families. The industrial revolution paved
the way for engineering and new technological advancements. The explosion of modernism,
between 1910 and 1930, continued developing until 1945 when the Second World War ended
and the “baby boom” began. The economic confidence that people in the United States had after
World War II allowed for some risk-taking related to the advancement of families and family therapy.

Modernism was marked by an obsession with evidence, science, and technology. The market economy and mass democracy allowed for the idea that the world was open to transformation by human intervention. These thought trends affirmed the power of humans to create, advance, and reform their environment by using scientific knowledge, expertise, and experimentation.

Modern society demonstrated observable functional components such as the nuclear family, and gender roles. Though these components did not necessarily all fit with the core idea of equality for all people, they eventually provided concrete positive social changes for modern times. These changes were needed in order for the upcoming postmodern ideas to become successful. One functional component that was greatly impacted was that of the family life. In particular, the influence of technology in modern times changed the tone and functioning of families.

Technological home appliances like the refrigerator brought about the change of eating habits of American families. In the 1940s foods like Cheerios, minute rice, powdered drink mix, packaged cake mixes revolutionaries the family. Use of frozen food and prepackaged meals became more common and even more so, it was common to eat on family night in front of the TV. This shows the impact of people who were empowered to advance their environment, which affected typical functioning.

During these changing years of modernism the second wave of psychology emerged. This framework was driven by problem-focused therapies (O’Hanlon, 1994). In reaction to the pathology focused therapies from the past, the modern therapies such as behavioral therapy,
family therapy, and cognitive approaches were the latest modes to use. Instead of searching for hidden meanings these therapies focused on the here and now, the presenting problem. Modern therapists did not seek to discover unconscious motives but instead focused on what the client asked to have fixed and how the clients’ changes might affect the system in which they live or function.

In the modern times, change, was not perceived to be as difficult as it had been in the past (O’Hanlon, 1995). Systemic views allowed for new ways of thinking – if one person in the system changed, everything else in the system inevitably changed. Human personality was seen as highly influenced by communication patterns within one’s relationship to self (self-talk) and ones relationship to others. A further look at the theoretical components of the modern framework will set a context for which to view the development of Adlerian theory.

Key theoretical components. The major theoretical components of the Modern era are the concept of first order cybernetics and the view of change occurring within systems. The original cybernetic model began in the early 1960s, and developed from ideas of engineering and computer science. The concept, cybernetics, offers a concrete explanation of how systems regulate themselves. This idea, applied to family therapy, allowed therapists to think about families in terms of how systems and patterns organize themselves and maintaining stability. This breakthrough in thinking changed therapists’ view of pathology from residing in an individual person (as it did during the traditional time) to residing in the context of the family system (Dallos & Urry, 1999). The American psychiatrist, Murray Bowen, was a modern pioneer in the field of family therapy and systemic thinking.

In contrast to traditional psychodynamic theory, the cybernetic model saw an individual’s resistance to change as a hindrance from the system itself (Dallos & Urry, 1999). The system
itself had power to maintain the status quo and continue with its family systemic patterns, perpetuating the symptoms. Metaphors such as a mobile were used to describe family functioning; if one piece of the mobile moved the whole mobile was thrown out of balance and had to continue moving to regain balance and compensate for the one piece moving.

Symptoms displayed by individuals were seen as functions promoting homeostasis of a family system, rather than an individual ailment. For example, a child may be displaying symptoms of depression, anxiety or a phobia so that a disengaged parental reunite and their marriage relationship strengthened by being forced to engage with one another. The idea of a symptom having a function within the system provided new implications for individual treatment of mental illness. Individual treatment became viewed as counterproductive to creating sustainable change. Systemic change within the family began to be seen as necessary for curing the symptoms. These systems theories operated based on modern assumptions of objectivity, knowable reality and the positivist scientific tradition (Naden, Johns, Ostman & Mahan, 2004).

The therapeutic relationship. Following in line with the modern philosophical concepts and the advancing technological world, the modern family therapist resonated with the theoretical changes in psychology. A modern family therapist was seen as an outside observer who would intervene in the family like an engineer would adjust a machine to better functioning. As experts, these skilled social science engineers were looked to for intervention and fixing. Therapists were knowledgeable in areas such as paradoxical interventions, behavioral techniques, and Bateson’s double-bind theory. Problems were found within the system and solutions were in the therapist expertise.

The role of a therapist was to enter into the system and the family organization, be accepted into the system, then unbalance the system, challenge the status quo and inevitably the
rest of the system would adjust appropriately. Clients were not seen as creating their own change but, therapists were the change agent. Somewhat similar to the traditional time, the client’s consciousness was seen by the therapist as something to outwit in order to promote change. Overall, the therapist was the expert engineer and mechanic who would strategically restructure the system to what the therapist knew to be healthier functioning.

*Key techniques.* The psychotherapeutic techniques for families that developed in the modern era trace back to Adlerian psychology. Alfred Adler was the first psychologist to conduct family counsels for public demonstration and education (Corey, 2005). Structural family therapy and strategic family therapy were two main therapeutic models in the modern times. These techniques assumed the ideal family arrangement and attempted to change structural boundaries or intergenerational boundaries toward a perceived ideal (Mills & Sprenkle, 1995). The modern model of family therapy expected the therapist to have a certain level of expertise in implementing these techniques.

Salvador Minuchin initiated the development of structural family therapy in the 1960s. The focus was on restructuring the relationships within the family in order to reduce the displayed symptoms (Corey, 2005). This approach was focused on boundaries, roles and rules within the family system.

Jay Haley had a large impact on strategic family therapy. He addressed concepts of hierarchy and power, and used strategic interventions such as paradoxical intention. The strategic approach viewed families’ problems as a metaphor for how the system was functioning as well as a real problem that that family was struggling with. The structural and strategic techniques were the most popular techniques for family therapy in the 1970s (Corey, 2005).
Tracing back to Adler’s work with families, many other systems thinkers followed. With the cybernetic model social scientists and practitioners moved forward in their abilities to conceptualize change and its lasting impact on a system. These leading modern figures promoted and advanced systems theory in a way that would forever shape marriage and family therapy. Following is an overview of how Adlerian ideas were expanded and applied during the modern framework.

*Adlerian psychology and the modern framework.* Notably Rudolf Dreikurs perpetuated Adlerian theory of individual psychology in the modern era. As a protégé of Adler, Dreikurs carried on and developed Adlerian Psychology in a practical way that modern families embraced. Dreikurs developed the Adlerian ideas of the purposefulness of behaviors. He suggested that human misbehavior is the outcome of one or four unmet basic human needs. The child’s misbehavior can be categorized into four areas: attention, power, revenge, and failure or a displayed sense of inadequacy. By applying this idea to children, Dreikurs worked with families to stimulate cooperative behavior without using punishment or reward. As the expert living in during the modern times, Dreikurs would identify the mistaken goal of child’s behavior and educate the parent(s) on practical techniques to use with their children. Dreikurs’ expertise and direct approach made a mark the field of family therapy. The mistaken goals of behavior have been used in other familial relationship – primarily within the context of marriage (Carlson & Dinkmeyer, 1981).

As part of the Commonwealth Fund’s “Program for the Prevention of Juvenile Delinquency” the child guidance movement began during the 1920’s and continued into the 1940’s. Dreikurs’ impact on parent education greatly influenced the child guidance movement. This was a community effort toward prevention of mental illness. Still greatly impacted by
traditional psychology, this movement was originally based on identifying the “problem child”, establishing child guidance clinics, and promoting community mental health. This framework was based on finding the mentally ill person or the identified patient within the system and using techniques, strategies, and tactics to implement change.

This child guidance movement was one in which the fields of psychiatry, psychology and social work were all involved. During this time, these fields of the helping professions were vying for prominence and the family came under increasing scrutiny of “experts”. Though the competing professions were all involved, the importance and focus was placed on community health and not on the procedures or status of the differing professions. Overall, Rudolf Dreikurs was a key player in expanding understanding of and implementing Adlerian theory and practice to help families of the modern era. Adlerian ideas were present during the modern times; so, how do they show up in the postmodern times – does Adler’s Individual Psychology become amplified within the developing postmodern framework or are his ideas fading away?

The Postmodern Framework

Postmodernism began to emerge as early as the 1960s (Pocock, 1995) but has primarily been considered as appearing across cultures in the 1980s and is still gaining energy today. The main idea of postmodernism is that knowledge and reality are subjective and dependent on the observer. The postmodern era is identified by a great respect for personal meaning (Mills & Sprenkle, 1995). According to this framework, meaning is created in individual people not in the definitions of experts. People, use language, and communication to convey individual meaning, and therefore partake in creating reality. Everything we know is our own construction of what we observe. Different from the traditional and modern assumption, that we can discover objective truth, postmodernism claims that people do not have direct access to one external reality or truth
but that truth is filtered through the lens of the individual, and even created by the individual. This notion gives less validity to the “experts who were the modern family therapists, the engineers who fixed the family machine.

In order to help individuals and families, a therapist in the postmodern times must to step into peoples’ reality and walk with them toward a better reality. But, in a postmodern world, who determines what a healthy reality or what healthy family functioning is? Whose definitions are right? How can an Adlerian therapist identify a mistaken belief when there is no way to assert that it is mistaken? How does the profession move forward with multiple definitions of healthy? These are some initial questions that therapists in the postmodern times must grapple with as they work to promote helpful change. The nature of individual reality construction is not the only postmodern philosophy that influences marriage and family therapy.

Not only do individuals create meaning and reality but also groups of observers create socially accepted realities. What is considered true is likely to have been arrived at by process of coming to social consensus. This is central to understanding why some stories come to dominate within certain cultures and other stories die out. Therapists in the postmodern context are confronted with the pervasive nature of socially dominant stories that individuals personalize in a way that negatively affects their lives. Cultural relativism, the assumption that culture affects peoples' perceptions, behavior, meaning creation and attitudes, and everyone is a cultural being has grown as a guiding concept and is perceived as more relevant now than in previous decades of marriage and family therapy (Hardy, 1993). In other words peoples’ definitions of reality are relative to the cultural contexts in which they participate.

So, is it “to each his own”; how can we successfully operate in a world were infinite realities are accepted? Socially constructed and socially accepted stories are influenced by
external constraints of our natural world. One example of how the natural world influences our acceptance of knowledge is to take into account what people consider true about edible and non-edible food. A banana is edible and a brick is not; this “truth” is a dominant one because it works with external constraints of the natural world. Though the constraints of the natural world impact socially constructed realities, social stories are often difficult to empirically test.

The paradigm shift from the modern era to the postmodern era has greatly influenced the field of family therapy. It has provided much more than a new set of techniques. It is a new way of thinking, a fundamental shift in the world of marriage and family therapy that keeps the field on its toes challenged with the speed of culture. The new epistemology lends itself to an open definition of ‘family’. It also impacts how therapists conceptualize and practice: sustainable change, their therapeutic relationship with clients, and the therapeutic techniques that will be employed (Mills & Sprenkle, 1995). Teaching and supervision have also been challenged due to postmodern thought (Hardy, 1993; Pare & Tarragona, 2006; Triantafillou, 1997). A look at the theoretical components of postmodernism and the impact these factors have on family therapy methodology will reveal how Adler himself was ahead of his time and his individual psychology resonates well with the postmodern ideals.

Key Theoretical Components

The paradigm shift of the postmodern framework is characterized by the development of new epistemologies. Concepts such as second-order-cybernetics, constructionism and social constructionism have great significance to the current beliefs of how we know what we know (Mills & Sprenkle, 1995). These ideas not only influence the role a therapist plays in promoting change but the modalities of practice that a therapist uses.
Second order cybernetics. In the early 1980s biologist Humberto Matura, cognitive scientist, Francisco Varela, and cybernetician, Heinz von Foerster, challenged the idea of an objective observer (Mills & Sprenkle, 1995). These contributors asserted that because we process information internally the information is subject to our own private way of organizing information and interpreting it. Therefore, reality as we each view it is largely our own construction. Matura’s work presented ideas about the mechanics of perception. He asserted that each family member has a unique description of his or her family system. Each person’s description was to be viewed as a portrayal of a different system, not different descriptions of the same system; and one description is not more valid than another. This new way of looking at the family system and family therapy directly challenged the ideas of the original cybernetics model, known as first order cybernetics. People’s different punctuations of reality do not suffice, because who decides whose reality is valid and whose is differently punctuated (Pocock, 1995). Since there can be no objective reality, the therapist, must relinquish the idea of being a neutral objective outside observer, relinquish the idea of being an expert and instead must come to peace with his or her own influence on the system as he or she interacts with it.

Second order cybernetics was an expansion of first order cybernetics. It took into consideration the therapist within the system. The therapist, simply by being an observer plays a role in constructing reality (Mills & Sprenkle, 1995). Therefore, the importance of the therapist within the system, as a co-constructor of reality, is appreciated alongside the equally valued perspectives of the rest of the experts within the system, the other family members.

Second order cybernetics placed little importance on the purpose or function the symptoms had within the system. Instead of asking what purpose the symptom served, second order cybernetics attempted to explain why the larger problem perpetuated itself as a problem.
Problems become problems because of the differing ways people view or punctuate events. The therapist was an active participant in deconstructing and reconstructing the families’ perceptions of their problems and therefore changing their reality.

**Constructionism.** Blooming out of second order cybernetics was an idea known as constructionism. In 1984, cognitive psychologist Ernst von Glasersfeld contributed to the popularizing of this term as he presented his theory of *radical constructionism*. His model, resonating with Matura and Varela, suggested that reality is not discovered but constructed, invented by individuals’ response to his or her perceived world (Mills & Sprenkle, 1995). Constructionism is a scientific metaphor. It came out of the roots of biology describing the physical properties of individual’s perceptions and processing. William James, (1943) (as cited in Pocock, 1995) described practical truth as ideas judged by their perceived usefulness for humans as we experience the world. Practical truth is sometimes influenced by constraints that can block helpful change. People often choose between sets of ideas by adapting whichever set of ideas best fits with the reality they are trying to describe.

Constructivism is a powerful concept that radically altered people’s philosophy of change. We are not pre-given our social world but actively create it and participate in it (Dallos & Urry, 1999). If one can construct reality then even difficult life situations are open to more workable personal cognitive reconstruction and interpretation (Mills & Sprenkle, 1995).

As the beliefs and values of the postmodern family were shifting, family therapists were in need of a conceptual framework that would remain stable in the changing times. People’s ideas about their lives and more importantly, the meaning they attached to those ideas, became the most important topics in the therapeutic conversation.
Social constructionism. Social constructionism, sometimes called third order cybernetics, is rooted in a philosophy of community. Its focus is on the formation of reality within groups rather than within individuals. Knowledge of the world is created through social communication; reality is whatever we agree it is with other people. Meaning is created and altered in conversation not simply in our individual minds (Pocock, 1995). As one can imagine, this expanded view of constructivism pairs well with family therapy. Reality is not simply a product of the individual mind but a product of our human relationships, which are continuously transforming at any given moment. A postmodern therapist participates in social construction of new realities for individual clients by addressing the power that the client’s family, peers, ethnic group and world have on their personal reality construction. The process of this social exchange changes each member of the system, including the therapist. Though the extreme end of this view rejects the idea of autonomous processing, the idea of social constructionism has become very popular in the marriage and family therapy field (Mills & Sprenkle, 1995).

We can never fully know the world ‘out there’ in a perfect or authoritative sense but the world is nonetheless fully real in the structures that influence, the actions that take place and the shared systems of meaning that triumph in larger cultural scales. The socially constructed shared ideas of culture are extremely important in shaping what is generally viewed as a problem and what is pathology. If we did not have any shared ideas about what a healthy family is or what constitutes problems in family functioning certainly there would be no way to ‘help’ someone; who would judge what was better functioning or more useful? Instead of viewing family functioning as right or wrong, one can see change as more helpful or less helpful. Such is with the field of physical health. If there were no social agreements about what a physically healthy, functioning human was, on what basis would personal trainers choose exercises to promote
helpful change or on what basis would doctors discern when to prescribe medicine? The commonly agreed realities help us function as individuals within society and within the world. These social agreements are dominant discourses that define our experience of the larger culture.

It is not easy to identify dominant discourses; they are not objective but continually shifting waves of meaning (Dallos & Urry, 1999). Two processes of discourse movement can be detected in culture. Top down process – where dominant discourses are internalized and affect us, and bottom-up process, where day-to-day conversations transform and reproduce larger discourses. Both top down and bottom up discourses are important in understanding our meaning formation. Within these discourses are words and meanings that are the formative pieces of how people interpret and apply the greater culturally accepted stories.

Language, meaning, and story. Two main ideas, collaborative language theory and the problem-determined system, entered the field of psychology in 1986 from the work of Anderston, Goolishian and Winderman of the Galveston Institute (Mills & Sprenkle, 1995). Their principles were grounded in appreciation for therapeutic conversation and held to the notion of social construction theory. Collaborative language theory explains the treatment entity as not only the biological family but also anyone who had a stake in the problem. Therapy is an opportunity to have members within the system, change their relationship to the problem. Through a dialogical approach, new views exchanged and less threatening interpretations emerge. This is by no means a strategic intervention to solve the problem but a controlled relational process.

In the postmodern framework, language is treated with caution because of its power to create, not simply present, reality (Pocock, 1995). For example, collaborative language theory
views problems being created because of system members intensely holding to and living by an unhelpful way of seeing a situation, a certain construction of reality (Mills & Sprenkle, 1995).

Therapists can reflect back the changes in the family that he or she perceives as proving useful; the evidence of what is useful must be based on the feedback from the family members (Pocock, 1995). Paying attention to clients’ own words and discovering the meaning of those words is profound in building the therapeutic relationship and creating change (Weingarten, 1998). As the therapist participates in this reconstruction process, new language begins to be used to describe the troublesome situation. Pocock, (1995) argues that better stories evolve when the therapist is involved with the family – stories that are more congruent, encompassing, shared, emotional, moral, and hopeful. This begs the question – what kind of a relationship does the therapist have with the family that is helpful in promoting change and aiding in the deconstruction and reconstruction processes?

The Therapeutic Relationship

Postmodern marriage and family therapy views families as cultures, active meaning making entities, rather than mechanistic systems (Pare & Tarragona, 2006). This alters the modern view of a family from something to be externally intervened upon, to a culture that needs new stories and new metaphors. This perspective alters the purpose and the style of the therapeutic relationship.

Many therapists have shifted their thinking from the modern strategic models to a more collaborative model (Hoffman, 1990). Postmodern therapists can be described as having respectful, collaborative stance with the clients as well as other professionals. The therapist is sensitive to each individual’s perceptions of reality and recognizes the larger influences such as social discourses related to gender, class and culture that impact in reality formation of the
individuals within relationship (Johnson & Lebow, 2000). Therapists strive to honor and even bring forth the client’s wisdom in dealing with their difficult situations (Weingarten, 1998). They are likely to focus on the couple’s or families’ strengths and competencies to highlight the positive characteristics that the couple or family already has that will aid in positive change for the system.

Though the therapist honors the client’s knowledge, no therapist can claim to be completely free of an agenda or intervention. Weingarten, (1998) describes a main component of her narrative practice as radical listening: moving attention from what she thinks about what the client is telling her to attending to what the client thinks about what they are sharing. Weingarten seeks to have all the voices in the clients’ stories be heard, including her own voice. Not shying away from self-disclosure, she participates actively in the reauthoring of the clients’ narrative.

Doan, (1998) studies postmodern therapists and their dialogue in sessions. They describe a postmodern therapist as having a decentered agenda. The therapist is continuously influencing the context of the therapy session. In order to affect the therapy session in a positive way the therapist must be centered and aware of their impact on the system. Their impact on the system naturally produces an agenda and it is an agenda to be continuously aware of during therapy and even used to further the therapeutic relationship and affect change.

This important aspect of the therapeutic relationship, the dialogical conversation, continuously moves the relationship between the therapist and the client. (Mills & Sprenkle, 1995) A collaborative language therapist facilitates a new dialogical conversation for the family system, one that was typically monological. By taking a “not knowing” position, a therapist attempts to leave all preconceived ideas about clients and their standard of health out of the therapy room. This allows the therapist to take a completely unassuming and intensely curious
posture about all of the possible meanings inherent in the problem system. Pocock (1995) uses his own interpretation in a therapy session to let the client know of his limited understanding.

This context of therapy is created and perpetuated by intensely respectful inquiry, which allows each person to honestly describe his or her consciousness of the other. The therapist helps the clients continue in dialogue about the problem so that both persons can hear each other and until the problem is no longer described in a problematic way (Mills & Sprenkle, 1995). The family system dissolves their problems by creating new systems of meaning through dialogue.

The “not knowing” stance of the therapist does not mean that the therapist has no expertise. Instead, the therapists’ expertise is in assisting the client to examine the fine details of his or her life story in order to discover what works for his or her life and the meanings the client attributes to what works; then the therapist encourages the client to do more of what works. This stance allows therapists to understand how the client constructs meaning. This opens opportunity for a not yet articulated narrative to begin to construct concrete change through a new story (Larner, 2000).

Second order cybernetics emphasizes reflectivity. The therapist, along with a supervision team, would form ideas about the family dynamics. These ideas were simply working hypotheses, not objective realities. There was no one true reality to discover. The therapist would continually question his or her perceptions as well as the team’s perceptions. Conflicting perceptions and beliefs held by individuals within the family was at the root of the problems. The therapist’s role then, is to help the family seek understanding and clarity within the system rather than upsetting the usefulness of the symptoms in the system.

Collaborative therapist must recognize the inevitable affect of the hierarchy of knowledge and influence, as well as their position that is informed by their own internalization of cultural,
political or gender discourses (Larner, 2000). The therapists’ knowledge is present but
deconstructed for the sake of the client; to have space for the clients’ own knowing and own power help within the therapeutic encounter. It does not mean that the therapist is unknowledgeable or that he or she is withholding knowledge from the client but it is what the therapist does with his or her knowledge to create space for a curious dialogue, which allows the couple or family to create their own new meanings that are more helpful for their functioning.

A postmodern therapist is an expert at helping the client feel empowered to be their own expert on their lives and use their expertise for implement their own change. Rather than the therapist promoting a vision of a better way, through direction of the therapist, the client creates his or her own style of solutions for his or her problems. The method by which a therapist actualizes these processes during a therapy session is summed-up in a few techniques.

*Key Techniques*

The impact of postmodern thought on the therapeutic relationship does not come without practical changes in therapeutic approaches and development of new therapeutic techniques. With application of the postmodern paradigm shift, especially concerning individual perspective, meaning systems, theories on human behavior and change, and the development of new treatment methodologies have grown as well. After a brief summary of solution-focused and narrative therapy, two main postmodern approaches, a literature review of solution-focused outcome research is presented along with suggestions on how Adlerian therapists living within the postmodern era can intentionally integrate helpful theories in practice toward creativity and effectiveness.

*Narrative therapy.* Narrative therapy is grounded in the idea that our lives are lived in narrative form and that reality is defined by the language people use and the stories they tell.
Gergen and Gergen (2006) assert that all forms of therapy reflect a form of narrative. A narrative therapist works with dominant cultural stories that are influencing the family system and enters in a process of exploration with the family. The exploration, based on a social constructionist view, gives attention to how knowledge, truth, and power work in relation to one another to perpetuate conflict.

The therapists help a families articulate and separate the stories that each member tells themselves and each other about who they are and how the world works. The therapist then enters these stories with hope to influence the story to be told in new ways or to even create new stories. Here the idea of deconstruction and constructionism comes into direct practice. A family is in the process of deconstructing their story and reconstructing a new reality.

Any therapeutic approach that works with the stories people have about themselves can be considered a narrative approach. White’s method of externalizing problems and Epston’s work with therapeutic letters are two specific key techniques in a narrative model of therapy. Michael White developed a way to help clients see their problems in their lives as separate from themselves – the process Michael uses is called relative influence questioning (Mills & Sprenkle, 1995).

When using relative influence questioning the therapist asks for two different descriptions of the problem; the first description is of how the problem affects the family and the second description is of how the family influences or affects the problem. Describing the problem from these perspectives helps family members see the problem as an object outside of themselves and their relationships. It proposes that the family has control and influence over the problem. Next, the problem is named and personified.
A therapist might say something like “hatred has caused a lot of problems, when was the last time when hatred didn’t get its way in your family?” This question is an example externalizing the problem and asking a unique outcome question where, in answering the question, the family begins describing situations where hatred gets its way and other times when hatred is defeated. Now the family members are positioned together against the problem instead of against each other. This stance, different from the problem-saturated stance of modern times, is less threatening and allows for new stories or modified stories to be possible.

One powerful technique in narrative therapy is the use of the written narrative. Examples of written document are certificates, letters, journals, & resumes. Narrative letters are common for regular use. The therapist constructs a letter to the client that highlights their last session, summarizes the problem and the affect that it has, and presents thoughtful questions that the therapist has related to the problem or the unique outcomes that the client has with the problem (Corey, 2005). This type of written narrative is intended to keep the client engaged with their change processes throughout the week.

Some criticize the movement of narrative therapy. Doan, (1998) directly challenge narrative therapists in their ability to practice what they preach in their own professional relationships. He asserts that narrative theory is just as much a socially constructed reality as any other set of ideas. While there will be issues to address with any new theory perhaps it is best to approach it from a pragmatic view and simply ask “does it work?” McLeod (2006) proposes that narrative therapy, in contrast to traditional individual psychological therapies “has the capacity to channel the energy arising from individual troubles, and shape it into productive social action” (McLeod, 2006, p207). One can infer that not only does narrative therapy help the individual but also larger social systems.
Overall, narrative therapy seeks to externalize the problem from the person or the family system, identify stories of unique outcomes when the problem has not been a problem and join in the reauthoring their story. Narrative therapists work on the postmodern premise of social constructionism and seek to help the client identify the dominant cultural narratives that are oppressing the family system.

**Solution-focused brief therapy.** Solution focused therapy – or as some might more properly say “solutions focused therapy” to imply the multitude of possible solutions to ones problem – has a growing number of supporters not only in the United States but around the world. It increased in popularity for family therapists in the early 1990s and is highly prevalent today (Mills & Sprenkle, 1995; Gingerich & Eisengart, 2000). Carpenter (1997) presents an editorial on solution-focused therapy and sites brief therapy as the “flavour of the month”. It is well liked by practitioners due to the high satisfaction reported by clients and it is well liked by funding agencies due to its brevity and low cost. It especially appeases HMOs because of its brief and concrete nature, and measurability (Carpenter, 1997). However, as a later review will show, solution-focused brief therapy does not have a strong base of empirical based outcome research scientifically supporting its effectiveness.

Notable people who have contributed to the development of solution-focused therapy are Steve de Shazer and Inso Kim Berg. The Brief Systems Group, led mainly by de Shazer and Berg, has worked to spread the principles of solution-focused therapy. Berg and de Shazer took what they learned about the problem-resolution approach from working at the Mental Research Institute in Palo Alto, CA with John Weakland, and began to augment it as they noticed clients describing exceptional times in their lives when their problems were absent or nominal (Simon &
Berg, 1994). They used this observation to launch a solution-focused approach to resolving client problems.

The basic assumptions of SFBT are as follows: 1) small changes result in bigger changes; 2) change is continual and inevitable; 3) the past cannot be changed so, concentrate on the future; 4) people have the resources necessary to help themselves: they are the experts; 5) every human being, relationship and situation is unique; 6) all of life is interconnected; 7) all problems have at least one exception; 8) therapy is not the only way people change, there are many things that are therapeutic (Simon & Berg, 1999). The rules of solution-focused therapy are: 1) if it is not broke, do not attempt to fix it, 2) once you know what works, do more of it, 3) if it does not work, then do not do it again, instead: do something different (Carpenter, 1997).

Similar to Bateson’s “news of a difference”, brief therapists prompt clients to identify when their problem has not been a problem. This is typically done using the exception question, which is, stated something like this: “Can you think of a time when this problem has not caused you as much trouble or when the situation turned out in a positive way?” These instances, when the problem has been absent in the client’s life, become the focus of therapy. The next step is for the therapist to ask questions that will produce answers that amplify behavioral detail of what the client was thinking and doing during the time when the problem was not a problem (Mills & Sprenkle, 1995).

Solution-focused brief therapy fits well with the main components of constructivist therapy (Mills & Sprenkle, 1995). Clients have the opportunity to construct their own solutions for their problems. Solution-focused, brief, therapists, help clients creatively imagine the possibilities by using the miracle question. It is usually asked like this: “If you went to bed tonight and while you were sleeping a miracle happened. The miracle is that the problem you are
here to see me about would be completely gone. How would you go about finding out that the miracle had happened? What would you notice that would tell you that a miracle had happened?” This line of questioning allows the client to begin describing what would be different in his or her life if he or she was not allowing the problem to be a problem. The client often describes what would be different about others in their life.

Additional questioning around the miracle invites the client to describe how they themselves would be different if a miracle occurred. At this point the client is creating solutions for themselves and articulating behavioral details of what she or she would be doing if he or she was to act “as if” their problem did not exist. This in and of itself provides open doors for practical change within the client.

Further questions – often scaling question from 0-10 – provide an opportunity for the client to stake a claim to their current position in relation to their miracle. The scaling is typically presented as “0” being the worst, or farthest away from the miracle and “10” being the miracle has come to full fruition. Then the therapist can ask the client what would be different if their number was just ½ a point or one point higher on the scale. This allows the client to think of small changes, and in alignment with solution-focused assumptions a small change will have a large impact.

The beauty of scaling from 0-10 is that rarely does someone ever choose 0. Typically people can always think of something worse that could be happening. This allows the therapist to inquire something like “what brings your number up to a 3 and what keeps it from being a 0”? This line of questioning puts the client in a position to begin articulating the things in their life, related to the problem, that are going well. This positive focused dialogue and theses detailed behavioral descriptions are therapeutic in creating change for the client.
Franklin, Corcoran, Nowicki, and Streeter (1997) conducted an experiment examining the use of client self-anchored scales for measuring progress. The study concludes that self-anchored scales are helpful because they produce both qualitative and quantitative results to measure progress (Franklin et al., 1997). The scales are particularly useful in that they use the clients’ own words and experiences as markers for change; this is a clear example of how solution-focused therapy fits with the postmodern ideas of constructionism.

A good question is the mode through which the therapist helps the client reflect on what works. Eckstein, (2001) outlines the use of solution-focused questions and Adlerian Psychotherapy in a relational process that reflects constructivism and social constructivism. The process outlined provides specific questions that couples or families can answer together resulting in self-assessment and insight. Still others (Beyebach & Carranza, 1997), have researched the therapeutic interaction in solution-focused therapy to identify why people drop out of therapy. A connection has been found between the therapeutic relationship – especially the relational communication between the therapist and client – as a stronger determining factor for client retention than the content that the client brings to therapy (Beyebach & Carranza, 1997).

The main focus of solution focused therapy is to find out “what works” for the client (de Shazer & Berg, 1997). After “what works” is identified and articulated by the client, future sessions include finding out ‘what’s better’ for the client and highlighting what he or she is doing that works when relating to his or her problem. The miracle question, exception question, scaling questions, a reflective team, and task assignments are all key characterizing aspects of solution-focused therapy. Adler himself helped clients identify what works by looking at the life tasks of individuals, the basis of Adlerian ideas fit well with the postmodern framework.
Adlerian Theory and Practice: A Postmodern Approach

Alfred Adler as a Postmodern Thinker

Adlerian theory resonates well with postmodern theory. Relational constructivism is a term that describes the convergence of two postmodern concepts: constructivism and social constructivism (Watts, 2003). In his theory, Adler implicitly and explicitly demonstrates the idea of relational constructivism by weaving both constructivism and social constructivism in his explanation of human psychology and change (Watts, 2003; Watts & Trusty, 2003). Though Adler himself did not live in postmodern times, his worldview was ahead of his time, and his application to psychology was postmodern in nature.

In Adler’s notion of “act as if” we can see how his theory practically lives out the idea that humans construct ways of viewing their experience of the world and take these constructions as truth (Watts, 2003). Adler believed in the creativity of all people in co-constructing their personality. He referred to this as the “creative self”. He also would say, “things could always be different” which is a phrase that explains Adler’s sensitivity to individual realities and his “not knowing” attitude. The Adlerian approach agrees with the importance of cognitive constructivism and the power it gives an individual as he or she actively and creatively constructs his or her own psychology.

Adler was the first to recognize the process of organizing meaning from our experience. His concept of “lifestyle” is essentially a metanarrative for how individuals, within a relational context of family and culture, assign values and rules to their unique world (Watts, 2003). The idea of each person having a unique lifestyle fits with the individualistic nature of constructivism. Our lifestyle is our teleological narrative, our unique way of moving through the tasks of life; it includes our beliefs, interpretations, convictions, and ethical standards that guide
us. This lifestyle is guided by “private logic” the unique beliefs one holds about life including how relationships should be, and image of the ideal self and a way of moving toward a goal.

Adlerian psychology affirms the idea of social constructivism in that human psychological development originates in sociocultural patterns. We are in an inescapable relational matrix but we also have the ability to step back and reflect on the matrix and individually impact it. Adlerian therapy accounts for the socially embedded nature of human knowledge as well as the personal capacity of self-reflective individuals within relationships (Watts, 2003). Adler believed that humans could not be properly understood apart from their environment. Our environmental experience and our own way of interpreting our experience blends together to create a both/and idea of constructivism and social constructivism.

Adler described the psychological development of children in terms of their environment, their family constellation, and family atmosphere. Birth order and psychological birth order are some of Adler’s main contributions to psychological theory. The premise of the relevance of birth order is looking at the individual within a system of relationships and situations and understanding their interpretation – the meaning they give to the circumstances.

It is not our circumstances that we should consider, but the meaning we ascribe to our circumstances that matter. Adler would agree: it is not the situations that have been handed to us but how we interpret and respond to those situations that are important. In postmodern approaches to therapy, the focus is not on the struggles or symptoms that a family is dealing with, but, how they ascribe meaning to their family system and how they respond and interact with the system based on that meaning to either perpetuate or eliminate the problems.

Adler placed importance on egalitarian relationships, equal rights for all persons, and the useful and useless political and power issues within those relationships. Adler observed that
humans tend to form attachments and that our striving is always attached to human connectedness and bonding. Social interest – the tendency to express desire for connection in a way that promotes human welfare – is a prime concept of Adlerian theory that fits with social constructivism. He asserted that the best way to assess psychological health was to develop social interest. Work with others to create meaning, this develops connections between people and a sense of belonging for people.

Long before positive psychology was named as a movement and long before multiculturalism became an emphasis in the field of psychology, Adler was promoting these ideas (Watts, 2003). Adler crusaded for social equality for women and racial minority groups. He had an innate bend toward the understanding of social embeddedness (Watts, 2003; Watts & Trusty, 2003). Adler knew that though dominant societal stories affected individuals, individuals could also create new meaning and impact society (the top down and bottom up nature of discourses). Today Adlerian therapy is practice within the context of postmodern epistemology and postmodern culture.

Adlerian Therapy as a Postmodern Practice

Adlerian therapy is a relational constructivist approach (Watts, 2003). First, it comes from a nonpathological perspective; it does not view the client as sick (having a disease). Instead, the Adlerian approach views clients as discouraged, demoralized and in need of hope. This resonates with other constructivist approaches. Similar to Narrative’s way of externalizing the problem Adlerian techniques do not view the client as the problem, but the mistaken belief or unhelpful interpretation is the problem. Clients are living as if their mistaken beliefs are true and therefore creating stories for their lives that are unhelpful.
The client is not sick; there is nothing to cure. Rather symptoms are considered proactive rather than reactive. Symptoms are consciously or unconsciously chosen by the client because they are perceived as aiding in reaching a desired goal. In this sense, symptoms are attempted solutions rather than evidence of illness. Adlerian construct is embedded in Postmodern practice. This can especially be identified in the following techniques: collecting early memories, assessing current meaning systems, asserting hunches, transforming memories, and finally creating new meaning systems. The therapeutic approach of conducting a lifestyle assessment is in a sense similar to creating a new story for their life.

Acknowledged by constructivism, often time’s people are reluctant to change. Adler summed up all problem-solving devices that people use to safeguard or protect their self esteem in one term: compensation. In order to move past the need for client compensation a strong therapeutic relationship with aligned goals – between the therapist and the client – is necessary (Dreikurs, 1967 as cited in Watts, 2003).

Adler’s view of the therapeutic relationship is highly similar to constructive therapeutic approaches. The relationship is considered a collaborative, equal, hopeful, respectful relationship, one in which two equal people join together to promote change. Building trust, exploring the clients’ strengths, and creating a therapeutic alliance are of prime importance in having a successful therapeutic relationship, both in constructivist approaches and Adlerian therapy (Watts, 2003; Watts & Trusty, 2003).

Adlerian therapists as well as constructivist therapists help their clients to focus on solutions and successes rather than problems and failures. In many postmodern approaches this shift occurs by changing behaviors and attitudes. In allowing clients to become aware of their mistaken beliefs they can then choose new beliefs to reinforce their desired lifestyle or their new
life story. Both Adlerian therapy and constructivist therapies are hopeful and future-oriented. By using positive language and encouragement, the therapist influences the client, promoting him or her, or the family, to make new meaning for their lives thus, improving their beliefs, thoughts, feelings, and behaviors.

In both SFBT and Adlerian therapy change typically begins with actions and behaviors (Watts & Pietrzak, 2000). In SFBT when working through the miracle question the clients are asked to articulate the first things they would notice if things were different. This initiates conversation about actual behavioral changes. Similar to SFBT therapy as Adler asserts, “trust only movement”. The tongue in the shoe must match the tongue in the mouth. This view of change does not discount or leave out the necessity for psychological change in beliefs, thought patterns, and feelings but simply highlights the concrete, tangible and notice as changes in one’s life as true change occurs.

Lewis, (2005) and Watts & Trusty (2003) articulate the Adlerian notion of “acting as if” as it relates to postmodern ideas and the practice of marriage and family therapy. Lewis, (2005) uses outlines how to use the Solving Circle with couples and families in a way that incorporates the act “as if” idea. Based on Glasser’s Choice Theory (1998), the solving circle allows a couple to reflect “as if” they knew what changes they need to make in their relationship. The solving circle is used as a solution focused, future oriented approach. The clients are asked to imagine they are six months in the future and describe what kind of progress they have made. Lewis, (2005) also explains the use of imagery teams in helping the couple socially construct solutions to their problems.

Watts & Trusty (2003) also uses the act “as if” idea along with an imagery team. They refer to this technique as using imaginary teams in reflecting “as if”. This approach integrates
constructivists and social constructivist’s ideas into practice. The therapist inquires about what would be different if the clients were the way they wanted to be. Also, using the imaginary team or an empty chair to represent other people in the client’s life a therapist asks the client to identify what the others in their selected imaginary team would say in response to similar questions. By having the client construct a new reality, the therapist is integrating constructivist ideas. Then having the client reflect what those around them in their systems of relationships would say, it utilizes a social constructivist view as well. This Adlerian idea of reflecting “as if” life were different resonates well with the postmodern paradigm.

Finally, in alignment with a narrative approach, Adlerian therapists help clients to discover their dominant life story and the mistaken or oppressive beliefs (or scripts) that they are living by in that story. Then through use of encouragement, the therapist opens up new pages of their story for the client to focus on their outcomes, their resources, their strengths, and their power in order to create new meaning and live their story differently. As one can see, not only can Adlerian therapy be practiced within the postmodern framework, Adler’s ideas are foundational to postmodern family therapy.

Research on Postmodern Techniques

Postmodern epistemology sees science as unable to confirm objective knowledge. The only scientific proof is of what is not true: hypotheses can only be refuted, never proven. One criticism of this perspective is that postmodern practice is missing a valid standard to measure therapeutic styles and practices (Doan, 1998). However, according to postmodernism, good science is like a collection of stories each of which is waiting for new data to come along to improve or change the storyline. Because of this paradigm, qualitative research is becoming more accepted in the postmodern times (Hardy & Keller, 1991).
It is important to review the current socially accepted story that science provides about the effectiveness of postmodern techniques. Relative to modern therapies, there has been fairly little outcome research published on the postmodern techniques. However, there seems to be something especially effective in narrative forms of therapy (Gergen & Gergen, 2006) but very few empirical studies have been completed testing the effectiveness of Narrative therapy. Narrative therapy is often used and has been qualitatively effective for therapy with people who have eating disorders (Lock, Epston & Maisel, 2004). In addition, ideas from narrative therapy have been combined with other therapies, such as cognitive narrative psychotherapy, quantitative research has been conducted, and positive results have been preliminarily shown (Goncalves & Machado, 1999).

Because there is a limited quantity of published empirical studies on the outcomes of narrative therapy, a detailed examination of solution-focused therapy will be presented. There are a growing number of empirical studies conducted on many different populations being completed using solution-focused therapy. A detailed review of research on solution-focused brief therapy – some published articles and others unpublished – is presented below.

**Literature Review of the Solution Focused Brief Therapy**

An overview of the outcome research in populations beyond marriage and family will be reviewed to best summarize the findings of the effectiveness of SFBT. Studies with couples and families, children and adolescents, adults and the use of SFBT in social work are all parts of the current research story of solution-focused therapy.

Gingerich and Eisengart, (2000) give the critical overview of 15 controlled empirical studies that have been completed through 1999. They divide these studies into three categories: strongly controlled, moderately controlled, and poorly controlled. Out of the 15 studies, five
were well controlled and the other two were moderately or poorly controlled. Gingerich and Eisengart (2000) conclude that these 15 studies completed before the year 2000 show preliminary support for the effectiveness of SFBT. They only reviewed studies in which client behavior or functioning outcomes were assessed and excluded studies that lacked experimental control and those that only measured client satisfaction. Three of the 15 empirical studies reviewed by Gingerich and Eisengart (2000), were unpublished doctoral dissertations.

Since 1999 additional empirical studies have been completed using Solution Focused therapy. In all studies have been done with children, adolescents, adults, and elderly, mentally ill and conducted in the realms of couples counseling, family counseling, school counseling, and in the area of social work. Though this writing will thoroughly review studies where SFBT was used in marriage and family therapy (relationships couples, parent/child etc), it will also briefly review other solution focused research that has contributed to the overall research base.

Studies with couples or families.

Most family therapy is brief therapy (Gurman, 2001). However, not all brief therapy or even brief family therapy is solution focused. The following studies used solution focused brief therapy with couples or families.

Nelson & Kelley (2001) and Zimmperman, Prest, and Wetzel (1997) conducted a research study with couples using a solution focused approach. Each study was based on self-report measures, was conducted in a group therapy setting, and produced significant results. A review of article will identify the similarities, differences, strengths and weaknesses of each experiment.

Nelson & Kelley’s (2001) research questions were based on couples’ change in marital satisfaction as well as progress toward their individual and couples goals. Naturally, self-report
measures were used. First, a pilot study was conducted; results were positive in the expected
direction so, Nelson and Kelley continued with further research. An advertisement was posted
for a relationship enhancement group and a sample was gathered. The total sample included five
heterosexual Caucasian couples three of which participated in the first group and two
participated in the second group. The couples were given an orientation to the process including
the research design and its theoretical underpinnings.

Nelson & Kelley (2001) used three measures to gather data: the Revised Dyadic
Adjustment Scale (RDAS), the Kansas Marital Satisfaction Scale (KMS), as well as a Self-
Report Goal Sheet (SGS), which was developed specifically for this study to match the solution-
focused approach. The RDAS is a six-point Likert-type scale containing fourteen items. The
questions included topics of dyadic consensus, satisfaction, and cohesion. As cited by Nelson
and Kelley, (2001) the RDAS measured an internal consistency of .90 (Busby et al., 1995) and
when correlated with the Locke-Wallace Marital Adjustment Test (MAT; Locke & Wallace,
1959) r = .66. The KMS is a seven-point Likert-type scale with three items related to relational
satisfaction. The SGS was designed using scaling questions to measure a couple’s progress; zero
signified no progress and ten signified completion of the goal. On this measure, the couple was
asked to scale progress without communication to their partner.

This study was conducted over an eight-week period with treatment for four consecutive
weeks. The RDAS and the KMS were used to establish baseline scores during the four weeks
prior to treatment. The SGS was added and used when group sessions began to measure progress
during treatment.

The couple’s therapy group sessions took place over the course of a four-week period and
consisted of one 90-minute session each week. The group sessions included assessment of their
current functioning, a review of the previously assigned homework, a short instruction on the focus of the current session, a task to complete in session followed by a dialogue, and the assigning of a homework task for the upcoming week. A solution focused treatment manual was developed by Nelson and Kelley (2001) and used in this study. The treatment manual included discussion guides and an outline of the homework tasks.

The first session was focused on the goals of the couple: goals that were specific, behavioral, and attainable. These goals were then scaled for current functioning to set baseline measurements. The homework tasks between sessions were: 1) noticing aspects of the relationship that the couple appreciated and would like to continue, 2) noticing positive change and identifying what interrupted problems, 3) utilizing strengths from other contexts in their relationship. During the fourth session, each couple practiced in sharing how his or her partner had positively affected the movement toward goal accomplishment.

At the end of the fourth session the couple completed the Revised Dyadic Adjustment Scale (RDAS). The results of this study indicate that about 75% of the sample made positive changes in their marriages during the time they were in group therapy. Upon measuring from pre-test to post test, five of the ten participants improved by one standard deviation or more.

Nelson and Kelley (2001) produced significant research in the sense that very few studies have been done on the effectiveness of SFT on couples. The small sample size, the non-objective self-report measures used are some complicating factors to the soundness of the research results. It is not clear that the positive changes occurred do to the treatment method, the therapist, the characteristics of the participants, or perhaps a combination of these factors.

The implications of this research do suggest that solution-focused couples’ groups are a viable treatment option. Participants reported enjoying the therapy and perceived it to have been
helpful for their marital relationship. This study confirms the importance of further research to
explore the differences between SFCT and SFCT in groups.

Zimmerman, Prest and Wetzel, (1997) conducted a study using two groups as well, a
treatment group and a comparison group. The treatment group was made up of twenty-three
married couples and the comparison group was made up of thirteen married couples. The uneven
groups are because more couples were interested in being a part of the treatment group. Subjects
were all from a medium sized university town.

A newspaper advertisement targeting couples who wanted to improve their relationship
was the invitation to join a six-week therapy group to work on communication, problem solving,
conflict reduction, and strengths of the couple’s relationship. Over eighteen months, sex groups
were offered. As one of the partners from each couple responded with interest, that couple was
assigned to an available experimental group. The control group was gathered by distributing
flyers to on-campus married student housing. Couples who participated completed the pre-test
and post-test but did not participate in group therapy. The couples who participated received a
coupon for a free interpretation of their scores, which could be redeemed after completing the
post-test.

Zimmerman et al. (1997) used three instruments as pre-test measures and two of those
also as post-test measures. The Marital Status Inventory (MSI) and the Dyadic Adjustment Scale
(DAS) were the two main instruments used. Both are self-report measures that have been found
to be reliable in differentiating between distressed and non-distressed couples. The MSI includes
fourteen true/false questions measuring the overall commitment of each partner to the
relationship while the DAS is a thirty-two item measure that asses overall marital adjustment
using four subscales: Dyadic Consensus, Dyadic Satisfaction, Affectional Expression, and Dyadic Cohesion.

The authors of this study acknowledge that they did not know of the RDAS at the time the experiment was conducted so, the DAS was used. The MSI was used as a pre-test only to produce a baseline level for marital distress. This allowed an assessment of significant pretreatment differences in the couples.

Six therapy groups consisting of three to five couples each, met once a week for six consecutive weeks. Each 90-minute session was audio taped to review and critique the procedures used by the facilitators. The facilitators were male/female co-therapy teams of which the therapists were current or recent students from the graduate school and had a strong background in solution-focused therapy.

Zimmerman et al. (1997) used a similar treatment format as Nelson and Kelley (2001). The session content was based on a book called *Divorce Busting* by Weiner-Davis and a solution-focused therapy model. The first session began with a group orientation to the process, ground rules for the group processing, and a review of the theory that was informing the practice. The first session also contained a psycho educational component on goal setting and the homework was focused on having each participant write out a goal they have for being a part of the therapy group.

The second session helped the couples to focus on what is working in their relationship. There was a pattern in the processing of this second session. Many couples realized that they often overlooked small changes in their relationship and the effects that those changes have. In this session, participants shared their goals with the group and reviewed the goals for the goal-setting guidelines including stating the goal in positive, specific and attainable.
The third session emphasized a discussion of what changes the participants noticed in their thoughts, behaviors, feelings and which changes the participants would like to have perpetuated. The psycho educational piece of the third session was about pattern recognition and strategies for interrupting problems. In the group the couples shared about their own patterns and used each others’ ideas for pattern interruption or perpetuation. The session three homework the couples were invited to interrupt one negative pattern or enhance a positive pattern.

Session four addressed the techniques the couples were trying that were not working. This part of the process does not seem to fit with solution focused approach, however the participants were encouraged to surprise their partner by doing something different which is a solution focused technique. Session five and six addressed how to keep the changes going and what to do if plans seem to be causing a negative effect. In session five participants made lists of choices and behaviors that they perceived as necessary for continued change; this reinforced their self-created solutions.

The results of Zimmerman, Prest and Wetzel’s 1997 study are impressive. Comparing the pre-test and post-test DAS scores, the positive changes were significant not only in the overall DAS score but on each subscale. The couples’ self reports of change included information that the couples were: having shorter and less intense arguments, better able to accept each other’s differences, increased physical affection, making more time for each other; engaging in more effective problem-solving, blaming each other less, focusing on solutions, experiencing a greater sense of calm and capacity for spontaneity in the relationship, and awareness of problem patterns (Zimmerman et al., 1997).

As reviewed by Gingerich and Eisengart, (2000) this is considered a moderately controlled study. Its strengths are apparent. Because it was conducted in a university clinic, the
treatment protocol was able to be verified and the purity of the solution focused techniques could be scrutinized. Also, because careful statistical analysis was completed and standardized measures were used at pre and post-test the results validity of this study is increased. One of the weaknesses of this study is that it was not a randomized design. The subjects were recruited and were self-determined as distressed and nondistressed. In the end, the distressed group’s measures were closer to the nondistressed group’s measures which lends validity to the results of solution focused brief therapy for couples in group therapy.

In addition to the research on SFCT in groups, there have also been studies that assessed solution focused therapy with families (Eakes, Walsh, Markowski, Cain & Swanson, 1997; Lee, 1997; Macdonald, 1994; Macdonald, 1997). Lee, (1997) asserts that solution-focused brief family therapy is effective and applicable to families with diverse backgrounds. This one-group posttest design included fifty-nine families and was conducted at a children mental health facility. It was a descriptive study based on client self reports. The researchers posed the question “what are the relationships between respondents’ reported goals and family presenting problems,” and “what are the relationships between goal attainment, children and family variables and therapy variables?”

Participants received a six-month follow-up call after their family therapy ended. The phone call was from someone who had no previous contact with the family. A fourteen-item questionnaire was used to gather information about the family’s goal attainment, current status of the problems addressed, any new problems that developed, and the increase of positive changes. Other follow-up questions were used to investigate the therapists’ actions and words that the client perceived as helpful and unhelpful. The data was then reviewed by four people and a coding system was developed to analyze the data.
There are many variables within this study; not only in the length of therapy, but also who within the family participated in therapy, how many therapists conducted the therapy (either individually or in teams), the types of problems that families presented, and the number of sessions of which the family participated. The families participated in an average of 5.5 sessions over an average of 3.9 months.

Ten cases were not included in the published results due to lack of information on goal attainment. 83.6% of the respondents reported that overall therapy was helpful. Overall, the results indicate that the client perceived being supported and validated as the most important factor in their counseling process. The results also indicate that therapists who hold too rigidly to the techniques can be portrayed as artificial, overly positive, and intensive, which all negatively affect the therapeutic relationship and the progress of meeting the goals. This demonstrates the relevance of social constructivism - the premise that it is not as much about what a therapist does, but how he or she does it and more importantly, the meaning that is constructed by the client about the therapists’ behavior.

Future studies using a control group and pre-test and post-test standardized measures will be necessary for the validity of solution focused brief therapy used in the context of families. It appears from the presented studies that solution focused therapy has initial support from science in working with couples and families with a multitude of presenting problems. Further studies focusing on children, adolescents, adult psychiatry, as well as social work, give SFT a greater base of outcome research.

Other researchers (Eakes, et al, 1997; Macdonald, 1994; Macdonald, 1997) have also used solution-focused therapy for families. Both of Macdonald’s studies (1994 and 1997) used the ideas of brief therapy. His 1994 study used a multi-disciplinary team the therapy took place with
one main therapist and a team behind a one-way mirror and gave directions to the main therapist. Task assignments were developed and adjusted based on the therapists’ perception of whether the client was a ‘customer’, a ‘complainant’ or a ‘visitor’. The information gathered was based on 41 clients and their experience in brief family therapy. The average length of treatment was 3.17 sessions over 3.84 months. The length of treatment varied greatly between males and female clients. Male clients ranged from one to five sessions while the female clients ranged from one to 13 sessions.

One year after the treatment, a follow-up questionnaire was mailed to the clients as well as their general practitioner. The information was considered as a “good outcome” if either the practitioner or the client indicated that the problem was solved. If the patient and client information differed, the client information was preferred for data analysis. 70% of the cases reported a good outcome. In his follow-up study, Macdonald (1997) found that out of a sample of twenty-three cases 64% had a good outcome with brief therapy.

Eakes et al. (1997) used solution-focused brief therapy with families who had a family member diagnosed with schizophrenia. The sample consisted of ten patients with schizophrenia; five in the control group and five in the experimental group along with their family members. The Family Environment Scale (FES) was used as a pre-test-post-test measure. A control group received traditional therapy from psychiatric nurse and regular medical checks. The experimental group’s patients and family members completed five sessions of therapy.

No significant differences were found on the overall FES scores however, one notable and statistically significant difference was found in the increased level of expressiveness within the family for the post-test group. Eakes et al. (1997) attributes this change in expressiveness to the communication loop between the therapist and the families as well as the nature of the non-
hierarchical therapeutic relationship, which encouraged open expression of client ideas, feelings, and concerns. The therapists focused on identifying solutions, externalizing the problems related to schizophrenia. Overall, these results suggest the potentially stronger treatment when including solution-focused family therapy along with medical treatment. Gingerich and Eisengart, (2000) consider this non-randomized study poorly controlled and sites its weaknesses, particularly the lack of generalizability to more broad populations and the lack of control for outside influences.

*Studies with children and adolescents.* A handful of studies have tested the outcome of solution focused brief therapy on children and adolescents (Hompson & Kim, 2004; LaFountain & Garner, 1996; Litterell, Malia & Vanderwood, 1995; Springer, Lynch & Rubin, 2000). Litterell et al. (1995) is a moderately controlled study (Gingerich & Eisengart, 2000). Litterell et al. (1995) used single counseling sessions with high school students who were having academic and social problems to test the effectiveness of single session solution focused therapy with adolescents. With a sample of 61 students, the average age of the student was 16-years-old; most students were freshman in high school however sophomores, juniors and seniors also participated.

Litterell et al. (1995) tested the students in three groups using three treatment modalities: problem focused brief therapy without a task, problem focused brief therapy with a task assignment and solution focused therapy with a task assignment. Three Caucasian counselors were trained for ten hours in brief therapy. The training included some practice sessions where the counselors were given feedback on their technique of brief counseling. The students were randomized into three testing groups, one group for each type of brief therapy treatment. The treatment consisted of one counseling session (which averaged 40 minutes) and two five-minute
follow-up sessions, the first completed at two weeks post treatment and the second completed at six weeks post treatment.

The researchers used both quantitative and qualitative measures. The researchers developed a seven point Likert scale for a post-test measurement. This measure was completed by the student along with the counselor at the follow-up sessions. Also the researchers gathered qualitative information by randomly choosing ten students to interview. The qualitative data was measured against the quantitative data to assess the reliability of the students’ perceptions of the process.

Results indicated that none of the treatment modalities was significantly more effective than another in eliminating the students’ concerns. All students’ concerns were decreased during this experiment. All three brief therapy approaches helped the students move toward their goals and decrease their uneasy feelings about their concerns. Though the solution-focused brief therapy with a task demonstrated the most significant progress toward the students’ goals, no approach was statistically more significant in reaching the students’ goals. Overall, the counselors in this study perceived that empowering the students was the most significant aspect – more significant than goal setting and task assignments – to the change process; the students appreciated the concrete intervention.

Many have presented concerns about brief counseling. Litterell et al. (1995) suggested that the urgent nature of addressing the problem or the solutions of the presenting problem can hinder discussion of other more serious problems underlying the students’ presenting problem. Brief counseling seems to be helpful. Litterell et al. (1995) also brings into question whether solution-focused brief counseling is really more effective than problem focused brief counseling.
Brief counseling is suggested as not being a good tool for problems such as abuse, eating disorders, and suicide (Talmon 1990 as cited in Litterell et al., 1995).

Springer et al. (2000) tested solution-focused therapy with a group of children whose parents were incarcerated. Five subjects participated in a control group and five in an experimental group. The groups were not randomized; the school counselor requested that the teachers refer any students whose parent is incarcerated and whom might benefit from group therapy. The first five students made up the treatment group and the second five made up the comparison group. All students were in 4th or 5th grade where Hispanic American and had a family member in prison.

During the first three of six group therapy sessions the facilitators set the ground rules for the group, used solution-focused questions including the miracle question and scaling questions, created space for the children to share their goals with each other, led group actives such as collage making. These activities build the group cohesion and allowed for sessions 4-6 to be characterized by high levels of self-disclosure and a supportive atmosphere of listening and positive reflection about the group experience.

The Hare Self-Esteem Scale (HSS), a 30-item Likert-type instrument was used to measure the children’s self-esteem related to home life, peer relationships and school. Prior to any contact with the facilitators, all subjects completed the HSS as a pré-test and also completed it again immediately after the last group therapy session. The scores of the treatment group showed increased self-esteem of four points while the comparison group’s mean self-esteem dropped one point during this testing period. Although the treatment groups’ self-esteem increased, no statistically significant information was found when completing an ANOVA however when measuring the effect size a moderate result of .57 was founded; it is speculated
that Type I error may have impacted this research. A small sample size, only measuring the
variable of self-esteem, and testing a very specific sample population these results have some
limitations. They cannot easily be applied to other populations.

LaFountain and Garner, (1996) present a moderately controlled experimental study
(Gingerich & Eisengart, 2000) using solution focused therapy with students in groups. The
sample included elementary, middle and high school students. The 57 participating counselors
were randomly assigned to the experimental and control groups. The counselors in the
experimental group were trained in a one-day workshop on leading a solution-focused group and
received a treatment manual.

All counselors chose four to eight students who met the criteria for participating in a
solution-focused group. The treatment included eight weeks of solution-focused group sessions.
The control group received no treatment but all participants completed the pre-test and post-test
measure, the Index of Personality Characteristics (IPC). Statistically significant results were seen
in three of the IPC subscales: Perception of Self, Acting In, and Nonacademic. This indicated
that students in the experimental group had higher self-esteem in areas not related to academics,
had more positive feelings and attitudes about themselves, and had better ways of dealing with
emotions. This study concludes that solution-focused groups are not only helpful for students in
their self-esteem and their ability to cope but also for school counselors who are managing large
caseloads and are vulnerable to burnout (LaFountain & Garner, 1996).

A more recent study, Hopson and Kim, (2004) present a solution-focused approach to
危机干预与青少年。Hopson and Kim, (2004) site previous efficacy studies with
children and adolescents that indicate positive results for solution-focused therapy with this
population and describes in detail the value of a strengths-based approach to helping adolescents
in crisis. In this model the authors reflect the characteristics of solution-focused therapy including active listening, taking the clients’ perspective, helping clients define concrete measurable goals. Using solution-focused therapy with adolescents in crisis is especially helpful because it empowers the young person, who often feels overwhelmed with self-blame (O’Halloran and Copeland, 2000 as cited in 18) but, is encouraged as the solution-focused therapist is an expert at asking questions for the client to identify his or her strengths. Overall, the solution-focused therapist immediately joins with the client, actively listens to understand his or her description of the problem, and compliments the client on every success or times he or she has used to cope so far with the problem. The adolescents in crisis are able to come out of the crisis with confidence and increased awareness of their already existing strengths to deal with problems as well as new skills to cope with future problems.

*Studies in social work.* Sundman, (1997) found that when solution-focused ideas are used in social work there were an increase in the focus on goals, the positive statements used and the shared views between the clients and the social workers. This study was conducted in Finland with 382 randomly selected cases from the social workers case loads. Social workers reported on their clients’ progress toward goals and on their own helpfulness. Out of a possible 124 variables, 24 were found to be statistically significant. This study is considered poorly controlled due to the poorly defined implementation intervention and the biased outcome measure (Gingerich & Eisengart, 2000).

Overall, in his 1997 study, Sundman concludes that social workers using solution-focused framework were able to have a more positive and boarder view of their clients’ situations. Clients were able to focus on a few clear goals and work on them themselves with less work from the social workers. As one of the most important aspects of client success (Strupp,
1996), the therapeutic relationship was improved as the social worker approached the situation from a different paradigm.

Two other articles (Lee, Greene & Rheinscheld, 1999; Walsh, 2006) review solution focused approaches in social work. The first addresses child protection and outlines more specific ideas for a shift in practice. The rigid formulas for assessment and interventions do not allow for therapeutic space to help the family change (Walsh, 2006). This article calls for a “‘both/and’ perspective: both care and control, both safeguarding and supporting, both enabling and challenging” (p.48). The main idea is for the social worker to balance their authority and their ability to support and empower the clients to make change.

Another study, proposes a model for solution-focused therapy in a group treatment for male domestic violence offenders (Lee, Greene & Rheinscheld, 1999). The model is based on three years of experience that one of the authors has in running a short-term solution-focused group for male domestic violence offenders. The authors note that focusing on strengths and solutions should never be seen as minimizing the destructive behaviors (Lee, Greene & Rheinscheld, 1999). They report that during an almost four year period in the 1990s, 88 out of 117 men (75%) completed their solution focused group and the recidivism rate was seven percent.

Many areas of social work are focused on pragmatism, the immediate urgent needs; however, solution-focused interventions provide an approach to social work that can be considered pluralistic. Based on social constructivism, the solution-focused approach helps empower the individuals within a system to construct solutions to their problems. It is a societal effort to provide pragmatic solutions for the immediate problems while changing the socially constructed stories that perpetuate social problems (Lee, Greene & Rheinscheld, 1999).
Studies with adults. Lambert, Okiishi, Finch, & Johnson, (1998) another poorly controlled study according to Gingerich and Einsengart, (2000) did not use non-random assignment. With a population of adults in outpatient treatment, Lambert et al. (1998) tested SFBT and its efficiency in treating mental health problems like mood disorders, anxiety, substance abuse, and adjustment disorders. The sample contained 27 adult clients in the experimental group - treated with SFBT for two to seven sessions, and 45 clients in the control group - treated with eclectic psychotherapy for an unlimited time-frame. 46% of the experimental clients were considered recovered after seven sessions.

One other study tested solution-focused brief therapy with adults who have developmental delays (Stoddart, McDonnell, Temple & Mustata, 2001). This study found that the higher functioning clients as well as clients with stronger social supports benefited most from SFBT. Stoddart et al. (2001) suggests that rather than asking if SFBT is statistically effective, the better question is to ask is for which populations and which types of client problems is SFBT effective.

Outcome research has come into question. Treatment in the field of marriage and family therapy is considered systemic, yet there are no effective ways to measure systemic change (Doan, 1998). Though qualitative research is not generally considered scholarly, it is a growing trend as more and more marriage and family therapy training programs, and even doctoral programs, are putting emphasis on qualitative research. One of the assumptions of solution-focused work is that small changes make a huge impact. Though the outcome research presented here shows what seem to be small positive changes, according to the theoretical assumptions of solution-focused therapy, these small changes are highly important.
Now, having a history of the developing frameworks that led up to and contributed to the practice of postmodern marriage and family therapy, one can see how Adler himself was naturally ahead of his peers in his postmodern-type thinking. With the above history, a postmodern therapist must examine the characters that make up the current socially accepted story of outcome research that speaks to the effectiveness of postmodern techniques. With this knowledge, therapists can make informed and intentional decisions about how to better use or adapt postmodern therapies into their practice in meaningful ways.

A Theory of Continuous Development and Integration

In many ways the profession of marriage and family therapy within the current postmodern framework is stronger than ever, and in other ways there are risks to be aware of. Whether it be the industrializing world of the traditional framework, the mechanizing world of the modern era or the exponentially advancing technology and shifting epistemologies of the postmodern era, it is important to remember the meaningful developments that contribute to marriage and family therapy today. As new epistemologies develop and new therapy modalities are used it is common to get excited, swinging the pendulum in the opposite direction of the previously held frameworks. It is naïve to accept the latest new story without remembering the contributing themes from the previous stories.

The story of Alfred Adler, his contributions to systemic thinking and the continued practicality of his ideas today, are too valuable to go without notice and use in the postmodern world. Though psychoanalysis, and a primarily bio-medical model of individual therapy reigned during Adler’s career, and marriage and family therapy hardly even existed, Adler’s ideas undoubtedly contributed to the development of systemic thinking of the modern times as well as
the constructionism and social constructionism of the postmodern times. These ideas have primary influence on the field of marriage and family therapy.

Adler’s ideas were too forward thinking and not scientific or biological for his contemporaries of the traditional framework (Watts & Pietrzak, 2000). Though Adler’s theory applied during the modern times, his conceptual framework behind his theory best resonates with postmodernism. His constructivist approach viewed individuals themselves as systems; the functioning of the individual system characterized by, what Adler referred to as the lifestyle. This systemic way to view an individual provided a base for future systemic thinking and constructionist ideas to prevail.

As Adlerian therapists seek to help individuals within their context of marriage, family, and large social/cultural systems we must wrestle with the postmodern assumptions. So then, where does a postmodern Adlerian therapist land on the seemingly contradicting paradigms of modern and postmodern thought? Does one reality exist or is it constructed? Do we construct reality individually or socially? Is the therapist an expert, or is the client an expert? Should we look at parts of people or the whole person? Is change created in the system or in individuals within the system? Which is better qualitative or quantitative research? Are problems that clients present real problems or simply unhelpful stories that they have constructed? These seemingly contradictory ideas can coexist together and not be seen as either/or but both/and.

This author has come to conclude a “yes, both/and” perspective to answer these questions. Reality does actually exist, individuals interpret it, and through discourse, meaning is created and exchanged. Also, our construction of reality is impacted by the limitations of the natural world. The therapist is the expert, the expert at allowing the client’s expertise on their life to be utilized. It is important to view people compartmentally and holistically, as Adler did; he
looked at how the parts of the individual interacted to make up the whole system of the individual.

Change occurs within individuals, but only as they interact within their systems; and both qualitative and quantitative research help contribute to the story of social science research. Problems that clients present are very real problems with real effects on their lives but their interpretation or story about their problem can hinder necessary positive change related to the problem.

Pluralism and subjective reality are two areas with which to wrestle. Just because it is impossible to discover or agree on one objective truth, that does not mean that all interpretations of reality are true or that all are false. Perhaps it is more useful to think of peoples’ reality constructions and social reality constructions as helpful or unhelpful to their lives and to the greater systems in which they function.

A postmodern therapist can approach the exciting advancements in marriage and family therapy with hope for the future and a respect for the past. Though there are many differences between modern and postmodern philosophies, there are also many connections (Naden et al., 2004). The developments of systems thinking, even in a mechanical way, was foundational brickwork for the construction of constructionist and social constructionist thinking. Pocock, (1995) and Dallos and Urry, (1999) suggest a more hopeful story of modernism and postmodernism simultaneously impacting family therapy.

Other authors have learned to incorporate modern and postmodern ideas within their practice (Yerby, 1995). Yerby, 1995 argues that, in order for therapists today to better understand family communication, therapists today should adopt a process model that is based on a constructionist family systems framework that uses ideas of social constructionism and dialect.
Perhaps modern and postmodern ideas work together to provide a rich array of understanding and altering individual thought, relational patterns, meaning systems and widespread cultural stories.

Families are interpretive communities, story-telling cultures (Pare, 1995). Ironically as postmodern therapy moves, back toward a value of storytelling, technology continues to rapidly advance. A commercial plays on TV showing a new minivan that has personal entertainment systems on the back of each seat of each passenger. Incongruous with being isolated by entertainment and distracted from relational connection the advertisement reads; life is better shared together.

So, what is family in the postmodern world, and what meaning does this profession share about healthy family functioning? Is it fair to hold to the reality that children do best in authoritative communities and families that are well connected have better functioning? Can therapists look to past definitions of a healthy family and accept the changing definitions of family in our culture today? Fowers, 1996 abstract assets that postmodern therapists struggle because cultural ideals of families are closely attached with modern individualism.

These questions should not haunt marriage and family therapists but instead set them free to explore the different philosophies and epistemologies that have affected theoretical and clinical development of marriage and family therapy and systemic change. The task of wrestling with these frameworks and the foundational elements of Adler’s Individual Psychology in the postmodern world is no simple task. Nevertheless, it is a necessary step to take in order to have a critically examined knowledge and practice.

In an age of relativism where all views are considered equal and relative to other views, it is important for therapists to stake a claim for what “mentally healthy” is and what “healthy
families” are. If a doctor let every sick person decide for themselves whether or not they are sick, many of us would be in trouble. However as postmodern therapists we can leverage our modern expertise of what healthy is with our postmodern understanding of social constructivism and sustainable change to affect individuals, families and the greater culture.

Lebow, (1984, as cited in Naden, et.al., 2004) claims that integration allows therapists to be less bound by their own worldview and more flexible and capitalizing on their unique strengths. It is necessary for therapists to become self-aware in their own worldview and epistemological stance in order to best intentionally integrate multiple theories into effective practice. Intentional integration is vastly different from the haphazard eclectic approach to which many therapists default.

For the postmodern therapist, the use of self within the therapy is especially relevant because of the therapist’s active engagement with the family culture and each member of the family system (Real, 1990). Therefore, this provides even more reason for a therapist to have a clear understanding of what they are doing and a basis for why they are doing it. This solidifies the argument that a critical historical awareness, self-awareness, and cultural awareness are necessary elements of an ethical, integrity-filled, and successful practice.
References


