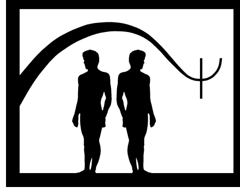

Solution-Focused Brief Therapy

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GLOSSARY

coping questions Techniques that are designed to empower clients to manage their life more effectively by addressing their coping style.

miracle question Technical intervention in which the client is asked to think in an unlimited range of possibility and to identify changes that they want to see happen.

scaling questions Technical approach that encourages the client to prioritize and put into an ordinal relationship various issues, including efforts to problem solve, as well as problems.

SFBT (Solution Focused Brief Therapy) is an approach to delivering psychotherapy based on a variety of theoretical positions, such as Milton Ericson's ideas and Wittgenstein philosophy of language. SFBT focuses on solutions rather than problems.

Solution-focused brief therapy (SFBT) was developed through the work of Steve de Shazer, Insoo Kim Berg, and their colleagues at the Brief Family Therapy Center in Milwaukee, Wisconsin. It is a model that has been developed inductively based on 30 years of sessions with clients. It has been used successfully in a variety of settings including rehabilitation centers, psychiatric hospitals, residential treatment centers, child protection agencies, schools, and private practices. This treatment model is based on the hypnotherapeutic work of Milton H. Erickson, as discussed by Haley in 1967, and influenced by the 1974 work of John H. Weakland, Paul Watzlawick, and Richard Fisch of the Mental Research Institute.

I. BASIC POSTURE

As the name suggests, SFBT is defined by its emphasis on solutions rather than problems. Different from problem-based therapies in which a great deal of time is spent assessing problems, understanding in as much detail as possible what a client is doing wrong, or developing hypotheses about what is wrong with the client and family system, and the therapist prescribing solutions, SFBT focuses on finding solutions and gives minimal attention to defining or understanding presenting problems.

A description of the SFBT treatment model includes the following: therapist attitudes, socializing, goal negotiation, miracle question, exception questions, scaling questions, coping questions, and the consultation break and intervention message. In addition, three types of client–therapist relationships are described: visitor type, complainant-type, and customer-type.

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Therapists' beliefs and attitudes influence how and what they listen to when talking with clients. SFBT emphasizes attitudes of client competence, and the importance of how language is used in conversation with clients. All therapists, regardless of their approach, come with certain attitudes and philosophies that affect how they do treatment. For example, all therapists are selective in their choice of what they ask about and what they ignore, depending on the underlying assumptions they hold about what is useful and helpful for their clients to talk about. Far from serving the "objective" purpose of "merely" gathering data, the questions therapists actually raise with clients influence and change clients' thinking about themselves. Solutions for clients are not scientific puzzles to be solved by practitioners, but rather changes in perception, patterns of interacting and living, and meanings that are constructed within the clients' frame of reference. The SFBT therapist assumes that clients are competent at conceptualizing an alternative more satisfying future and at figuring out which of their strengths and resources they can draw on to produce the changes they desire. The client is the expert of his or her problems and has legitimate goals and ways to facilitate change. For example, a client with an alcohol problem may want to improve his relationship with his wife and children and may not initially want to stop drinking. Accepting this initial goal as a reasonable first step makes it possible to further examine his desired state of life.

The therapist assumes a collaborative stance, with the client and therapist working together to bring about goals the client decides on. Berg and De Jong in 1996 described exploring and affirming clients' perceptions as clients describe them as a major share of what is done in SFBT. Even when clients are considering extreme actions—suicide or violence—they do so within a context of several associated perceptions. For example, to a client who thinks of hitting a child, an SFBT therapist might say, "What's happening in your life that tells you that hitting your child might be helpful in this situation? What else? Does it work? Suppose you were to do that, what would be different between you and your child? What would be different between you and your other children, the courts, your family?" As clients are respectfully asked about their perceptions, they usually are able to talk about less extreme possibilities. Berg and De Jong in 1996 described the therapist assuming a "not knowing" or curious stance in talking with clients. The therapist is always in the stance of learning the clients' perceptions and explanations, never knowing a priori the significance of the client's experiences and actions.

Finally, the therapist's job is to learn the language of the client. Rather than believing that language describes reality, it is believed that language also conveys information about what the therapist is interested in learning from the client. Being problem focused, clients often use language as if to describe their relationships and experiences, assuming, for example, that "being close" means the same for everyone. Often, although their language is very meaningful to them, it may be vague to a therapist. Clients use language to describe their relationships and experiences. Examples of techniques that begin to clear up the ambiguity are for the therapist to repeat key words used by a client, clarify what a client means by certain words, and use the actual words a client uses in the conversation. The therapist listens carefully for and explores each client's choice of words. This not only demonstrates respect for the client, it also begins a process in which, as therapists speak the client's language, clients begin to speak the solution-focused language of therapists.

II. SFBT PROCEDURES AND TECHNIQUES

All therapy, regardless of model, begins with a phase of socializing and orienting clients to what is to come. de Shazer and Berg describe initial questions directed at areas in which clients are successful or from which they draw satisfaction or esteem. Early on in the conversation, the SFBT listens for and highlights client strengths and successes. For example, beginning a conversation with clients by asking them what they are good at, what they enjoy, their job, hobbies, talents, past achievements, or ambitions for the future begins a dialogue between the therapist and client about identifying issues they both can agree are going well for the client. Client strengths, resources, and abilities are highlighted rather than their deficits and disabilities. This approach tends to look for what is right and how to use it. Asking clients early on what they are good at sets a different conversational path than "what problem brought you here today?" This communicates to the client that the therapist recognizes that even though the client has problems, he or she also has areas that are successful. Often these strengths, although unrelated to the presenting problem, bring early clues about how the client will solve their problems.

Co-constructing goals with clients is a very important feature of SFBT. Clients generally are much more aware of, for example, the problems and what they do

not want in their lives than they are about what they want to be different. Many clients begin the discussion of goals as the absence of problems; however, SFBT conceptualizes goals as the presence of what the client wants. Berg and Miller describe goals as criteria that the client and therapist determine together that would tell them they have succeeded and can end therapy. They include the following: Goals must be important to the client and be viewed as personally beneficial; they must be small enough so they can be achieved; they must be concrete, specific, and behavioral and stated in positive, proactive language about what the client will do instead of what he or she will not do. Goals must also be perceived as involving hard work for the client. For example, instead of drinking, a client may make an arrangement for a designated driver before going out on the weekend, or get to work on time. This is in contrast to a vague goal of improving one's self-esteem or being happy.

III. THE MIRACLE QUESTION

Berg and De Jong describe how the miracle question gives clients permission to think about an unlimited range of possibilities, and identify changes they want to see happen. Because the question has a future focus, it begins to move the focus away from their current and past problems and toward a more satisfying life. The miracle question stated in the following way frequently draws a rich response from clients.

> Suppose (pause) after we talk today, you go home (pause) and sometime in the evening you go to bed (pause) and in the middle of the night (pause) while you are sleeping, a miracle happens and the problem that brought you here today is solved (pause), but because this happens while you are sleeping, you don't know that the miracle happened until you wake up in the morning. So when you wake up tomorrow morning, what will make you wonder, "something is different, maybe there was a miracle last night?"

Getting details of the miracle is important and the therapist's follow-up questions are crucial. Asking "what else will be different, what else?" is a helpful question to explore. The more opportunities a client has to rehearse a successful outcome verbally, the more chance the miracle has of beginning in small ways to become real for him or her. The miracle question can be an empowering experience for clients as they begin to imagine a painful life transformed to a more successful and fulfilling life. The gift of hope and a vision can be a truly healing experience for clients.

Exception finding questions are another tool used in SFBT. An exception to a problem occurs when the client engages in nonproblem behavior (e.g., does not drink, does not feel depressed, and does not fight with his wife). The therapist's job is to listen for and magnify a client's successes through repeated emphasis on those few, but important, exceptions. When repeated often and examined in detail, successes become more real to the client. The client can then begin to see their success and recognize that they actually have taken steps to improve their life. Thus the client can take responsibility and credit for the solution. An example would be exploring in detail those times when a client does not drink: What was she doing?—Who was she with?—Where was she?—What did other people notice during that time? Other questions to ask include inquiring about times when things have gone better between sessions, and helping clients describe times when some pieces of the miracle have already happened before therapy began. Getting as much detail about what was happening during these times (who, what, when, where, how) and including other important persons behaving differently during these times, provide further contextual information in these important moments.

Scaling questions are another useful technique used in SFBT. As deShazer states, "there is magic in numbers." An example of a scaling question is "on a scale from 0 to 10, with 0 representing the worst things could be for you and 10 the day after the miracle, where on the scale would you say you are now?" Frequently, clients will give a rating of "3." The therapist then helps them describe the differences between "0" and "3" and how other people might see those differences, and what it might take to "get all the way up to 3." Suppose a client answers "1." The therapist may respond "How are you able to keep going?" "What gives you the strength to continue?" When a client is asked to put problems, successes, hope, and level of self-esteem on a numerical scale, it gives the therapist useful information about a client's relationships, confidence in change, and self-esteem, and helps to determine an end point for therapy. An example is, "At what number on the scale will you be when things are going well enough that you no longer feel you need therapy?" It can also help the client describe contextual details of his or her experience. An example is, "Where would your mom/dad/best friend/spouse/boss/probation officer say you are on the scale?" Finally, scaling questions can also help clients create small goals for change. Asking a client what will be different when they go from

a 3 to a 4 (not a 10), forces clients to think about taking small, more realistic steps toward change.

Coping questions can also be very useful in SFBT. Questions about how clients are managing their life can be very empowering to clients. Examples, include, "How are you able to keep going when your life feels like it's falling apart?" "How do you manage day to day?" Questioning clients about how they are coping with big problems shifts the conversation from hopelessness to hope and a sense of control. However small it may seem, the small things the client does to "barely cope" are the very things that the client must do more of "one day at a time" in order to create a basis on which to build more successes. "How come you life is not worse?" is used to "blame" the client for their success. Such "positive blame" assigns the responsibility for positive, helpful behaviors to the client.

Frequently, an SFBT session includes a team behind a one-way mirror and the therapist meets with them 10 to 15 minutes before the end of the session to develop a closing message to the client. Working alone (which is the most common practice) and taking a 5 to 10 minute break after 45 minutes of a session allows the therapist to review the session, take time to think about whether there are well-formed goals, and to decide on a feedback message for the client.

SFBT feedback messages include compliments, which are used with all cases and throughout the treatment process. All cultures use compliments as a means of cementing social relationships at all levels. Clients have personal qualities and past experiences that, if drawn on, can be of great help in solving their difficulties and creating more satisfying lives. Compliments can be direct or indirect. During the interview, for example, direct compliments can be developed from times when clients are resilient in the face of hardships, sober for even 1 week, able to hold down a job, care about their children, work hard, or are willing to come get help. Compliments are best when they are based on reality and incorporate the client's language. Indirect compliments are questions that imply that the client has done something positive. For example, "How have you managed to stay sober for one week?" "How have you managed to stay calm when things are so hectic?" This allows clients to speak aloud themselves about the details of their success. When clients are able to speak themselves, they appear more empowered in their ability to find solutions.

Suggestion for homework is frequently prescribed at the end of an SFBT interview. Deciding on what type of intervention to prescribe depends on what stage of relationship the client has with the therapist. SFBT describes three types of client–therapist relationships: visitor-type, complainant-type, and customer-type. Visitor-type relationships are those in which the client has not yet created a workable goal. Often these clients are mandated through probation officers, employers, or parents. Interventions with these clients focuses on giving frequent positive feedback on what the client is already doing that is helpful and working. Providing these clients with many compliments is often a very different message than what they have frequently heard, and may help make these clients more interested in treatment. Complainant-type relationships involve clients that have created some workable goals, but view their solutions lying outside of their control. In addition to using compliments, suggestions are made to shift the client's perception from someone who is a helpless victim to someone who can create solutions. Interventions encouraging clients to "observe and think" about what they will notice will be different when the miracle happens is an example. Because these clients are observers, but not yet "doers," this meets the client where he or she is. Customer-type relationships are those in which the client is willing to actively "do" something differently, to actually take steps to find solutions in his or her life. Clients are frequently asked to do more of what is working, pay attention to any part of the miracle that is happening, or imagine a miracle day.

IV. THEORETICAL FOUNDATION

The theoretical underpinnings of SFBT come from several sources including social constructionism, Wittgenstein's philosophy of language, and Milton Erickson's ideas on therapy. Social constructionism maintains that people develop their sense of what is real through conversation with and observation of others. Social constructionism holds that reality, as each individual perceives it, is by definition subjective and created through the process of social interaction and the use of language. SFBT asserts that problems occur in interactions between individuals and do not rest within any one individual. People define and create their sense of what is real through interaction and conversation with others, a form of negotiation carried out within the context of language. SFBT helps clients do something different by changing their interactive behaviors or the interpretations of behaviors. This approach makes no assumptions about the "true" nature of problems. SFBT has a strong orientation toward the present and future and further believes that everyone's future is

negotiated and created. How clients are currently living their lives and their future goals are emphasized, thus orienting the client away from the past problem toward the future solution.

This model differs from the traditional "medical model" in a number of ways. Rather than assessing problems, signs, and symptoms, SFBT assesses for solutions, exceptions to problems, and strengths within an individual and his or her social context. It further focuses on past successes, coping strategies, and resources and collaboratively co-constructs a solution with the client.

Language is a resource that is vital to all therapists' practices and relationships with their clients. The importance of language in SFBT is crucial. Gail Miller and Steve de Shazer in 1998 wrote about how meanings of words are inseparable from the ways in which people use them within concrete social contexts. Problem-focused language emphasizes what is wrong with people's lives, and frequently portrays the sources of our problems as powerful forces that are largely beyond our control or understanding. In contrast, solution-focused language focuses on finding ways of managing one's problems. Solution-focused therapists ask, "Since we talk ourselves into problems and solutions anyway, why not emphasize solutions." This is not to deny the deprivations and injustices in clients' lives, but to help get through and beyond them. This model uses postmodern assumptions that problems and solutions are talked into being, and meaning is changeable based on our use of language.

V. FOLLOW-UP STUDIES

Having been inductively developed in clinical settings by de Shazer in 1985, Berg in 1994, Berg and Reuss in 1997, and Berg and Kelly, in 2000, rigorous research that shows its effectiveness is only beginning to emerge. There is a great deal of informal studies scattered throughout in a variety of settings. However, a rigorous study design using random selection of population, controlled, and experimental groups, and pre–post measures is just beginning to emerge. We recognize that such data are necessary. What has emerged so far seems to show promise in its effectiveness and cost in terms of human suffering and dollars.

In 2000, Gingerich and Eisengart performed a review of SFBT outcome research. This article critically reviewed a total of 15 studies. Additionally, it reviewed early follow-up studies documenting SFBT outcomes.

Early follow-up studies used follow-up surveys by asking clients at 6 to 18 months whether they had met their goal. In the first study, de Shazer in 1985 reported an 82% success rate on follow-up of 28 clients. The next year, de Shazer et al. reported a 72% success rate with a 25% sample of 1600 cases. Subsequent studies by De Jong and Hopwood in 1996 and Kiser in 1988 have reported similar results. Other follow-up studies of SFBT have similar, but somewhat smaller success rates and have used subjective outcome measures, such as those by Lee in 1997, Macdonald in 1997, Morrison, Olivos, Dominguez, and colleagues in 1993, and Schorr in 1997. Although these follow-up studies provide feedback on SFBT outcomes, their lack of experimental control does not permit causal inferences to be made about the effectiveness of SFBT.

Gingerich and Eisengart reviewed 15 controlled studies that implemented SFBT, employed some form of experimental control, assessed client behavior or functioning, and assessed end-of-treatment outcomes. These studies were further divided into well-controlled, moderately controlled, and poorly controlled studies based on the number of standards met for assessing empirical support for psychological treatments developed by the American Psychological Association.

The well-controlled studies included studies on depression in college students, parenting skills, rehabilitation of orthopedic patients, recidivism in a prison population, and antisocial adolescent offenders (the studies were those of Cockburn, Thomak, and Cockburn in 1997; Lindforss and Magnusson in 1997; Seagram in 1997; Zimmerman, Jacobsen, MacIntyre, and Watson in 1996; and Sundstrom in 1993). Four found SFBT to be significantly better than no treatment or standard institutional services. Because these studies did not compare SFBT with another psychotherapeutic intervention, they were not able to conclude that the observed outcomes were due specifically to the SFBT intervention as opposed to general attention effects. One study by Sundstrom in 1993 compared SFBT with a known treatment (IPT) and found SFBT produced equivalent outcomes (no significant differences were found). None of the five studies met all of the stringent criteria for efficacy studies and thus one cannot conclude that SFBT has been shown to be efficacious. They do, however, provide initial support for the efficacy of SFBT. The remaining 10 studies contain methodological limitations that preclude drawing firm conclusion, but their findings are consistent with the general conclusion of SFBT effectiveness.

Gingerich and colleagues identify several future areas of need in subjecting SFBT to empirical test. First is the specification and proceduralization of SFBT itself with the consistent use of detailed treatment manuals

and treatment adherence measures. In addition, future efficacy studies will need to compare SFBT with other empirically validated interventions where therapist allegiance is equally balanced between treatments. Other considerations include specification of study sample, selection of the comparison group, adequate sample size, and using conventional diagnostic groupings.

Although the current studies fall short of what is needed to establish the efficacy of SFBT, they provide early support that SFBT is useful to clients, according to Gingerich et al. The wide variety of settings and populations studied suggests a broad range of applications, but this conclusion awaits more careful study.

See Also the Following Articles

Outcome Measures ■ Single Session Therapy ■ Working Alliance

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