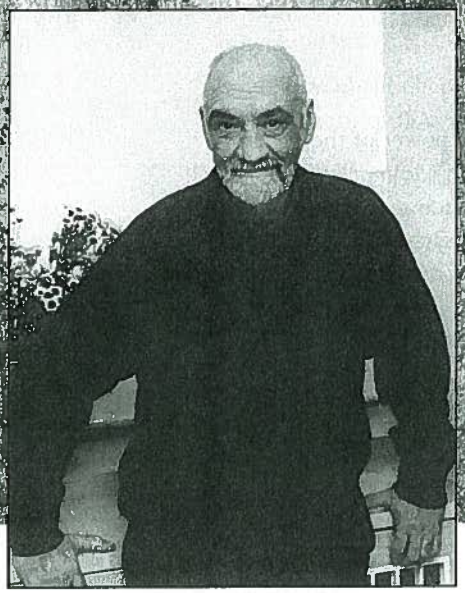
CHAPTER 14

Solution-Focused Therapy



Steve de Shazer

Kelly is a 22-year-old Caucasian male who comes to counseling to deal with problems of anger control. Currently working as a technical writer, Kelly earned his bachelor's degree in journalism 3 years ago.

Kelly is single (never married) and lives with his parents in their home in a large city. He has a steady girlfriend, Janet, and they plan to be married, but are not formally engaged.

Kelly reports that he wants to work on "problems with my temper." He sees himself as an "angry person" and reports being easily offended, tending to "blow up" when really frustrated. In the past, Kelly has occasionally thrown things when extremely angry, but never directly at anyone. Most often, these incidents happen when he is in conflict with his parents and less often with his girlfriend, Janet.

Kelly is perfectionistic about his appearance, environment, and work, and says that this perfectionism sometimes leads to an overconcern about details and frustration with others who do not share his standards. Although Kelly admits that he resents authority figures, he says that he does not have problems with his anger in work settings. Occasionally his "perfectionism" causes Kelly to be frustrated with the performances of his coworkers, but he is generally able to deal with this feeling in a constructive way. In fact, Kelly reports that he is more likely to be passive at work, accepting "mistreatment" from employers and remaining in an unfulfilling job despite feeling that he is not challenged by his work.

Kelly's nonverbal presentation is somewhat stiff and tense. He alternates between seeming angry and sad when he talks about his troubles.

BACKGROUND

What I am going to call Solution-Focused Therapy (SF Therapy for short) draws from two separate approaches, both of which are rooted in early communications/systems theory

and draw from the work of Milton Erikson (more on this to follow). The first variant of SF Therapy is associated with Steve de Shazer and Insoo Kim Berg of the Center for Brief Family therapy. A second version of SF Therapy is attributable to Bill O'Hanlon and colleagues. O'Hanlon has used the terms *solution centered, possibility therapy,* and *collaborative, competency-based counseling* to refer to his approach, but most recently seems to refer to it as Possibility therapy. Because *Solution-Focused Therapy* seems to be the most widely recognized term, I will use it in this chapter. A review of the history of this theoretical approach can be found in Cade and O'Hanlon (1993) and Nunnally, de Shazer, Lipchick, and Berg (1986).

de Shazer, Berg, and several other colleagues (principally Elam Nunnally and Marvin Wiener) established the Brief Family Therapy Center (BFTC) in 1978 in Milwaukee, Wisconsin (Nunnally et al., 1986). This group reports that their earliest sessions were conducted in the de Shazer-Berg living room, with one member of the team handling the video camera. From these small beginnings, the BFTC has grown to international recognition. The BFTC has a website at www.brief-therapy.org.

Most of the writers in the solution-focused tradition share an admiration of the work of Milton Erickson (see Haley, 1973, for a description of Erickson's work). In fact, Bill O'Hanlon served as Erickson's gardener for a year because he desperately wanted to train with Erickson and could not afford to pay for it (O'Hanlon, 1986). The solution-focused theorists were intrigued by Erickson's use of language, metaphor, and hypnosis to draw out clients' strengths so that they can be applied to current problems (de Shazer, 1982). In this process, Erickson could be seen to accept the worldview and life patterns of the client, helping the client to use them in new ways. de Shazer and colleague Joseph Berger spent a significant amount of time trying to develop a theory around Erickson's work, which, although it obviously involved interactional (communication) elements, seemed almost magical. de Shazer (1998) reported that these efforts were not successful; indeed "Erickson, it turned out, was correct in saying that he did not have a Theory. He perhaps had many theories, but not quite one per case" (p. 3).

Steve de Shazer and Insoo Kim Berg met at the Mental Research Center in Palo Alto (see Chapter 13 for more information on the MRI). Thus, Solution-Focused Therapy incorporates some of the ideas of the communications orientation to psychotherapy that originated at MRI (Watzlawick, Weakland, & Fisch, 1974). These researchers initially began their work by studying communication in families of people diagnosed as schizophrenic, finding that certain patterns of interaction were particularly common in such families. They later broadened their ideas to conceptualize most psychological dysfunction as rooted in interactional patterns. One of the most significant aspects of the MRI group's work as far as ST therapists are concerned is the conceptualization of client problems as resulting from "more of the same" syndrome, a cycle wherein clients' failed efforts to solve problems result in their trying even harder but using the same strategies.

de Shazer and Berg were married for 28 years, and died within a year and a half of each other fairly recently. Steve de Shazer passed away in 2005. His last book, *More Than Miracles: The State of the Art of Solution-Focused Therapy* (with Yvonne Dolan), was published posthumously in 2007. You can read a bit from this book in Box 14.1. A year and a half later, Insoo Kim Berg died unexpectedly on January 10, 2007. Berg had recently completed a book on coaching from an SF perspective (Berg & Szabo, 2005).

Box 14.1

The Therapist's Mind-Set Using the Miracle Question

We think it makes a difference whether or not the therapist assumes that clients have the capacity to create meaningful descriptions of what they want their lives to look like and how they want to be in the world. Asking the miracle question both implies and demands faith in the client's capacity to do this and the question needs to be asked in a manner that communicates this faith.

When asking the miracle question, or teaching the concept in training seminars, we have learned that the way you ask the question is very important, i.e., you have to ask the question as if you really want to hear the answer *and* you believe the client has the ability to give a good answer.

Some therapists are afraid to ask the miracle question because, they do not have faith that their clients have the capacity to answer it productively. This results in a sort of catch-22: Faith that clients experiencing serious problems will be able to answer the miracle question can only develop as a result of hearing clients respond beneficially; however, the therapist won't ask questions to invite these responses if he or she doesn't have faith in the clients' capacity to create them. If we believe that a client has the capacity to describe a problem then we must also believe that he or she is capable of describing what "better" than that problem would be.

Over the years in our training programs and workshops, we have heard people ask, "Aren't you afraid that this sort of question might lead people into false hopes or denial? What do you do if a client with AIDS says he won't have AIDS, or a man whose wife left him answers with "She'd be there in the bed with me when I woke up"?

We believe that in most cases people who come to therapy are all too aware of the realities of the conditions they are experiencing, and have the ability to recognize wishful thinking for exactly what it is. On the other hand, starting out by acknowledging what one hopes for that is not going to happen can be a first step toward identifying some useful things that *are* possible to make happen. Steve de Shazer tells a story of a client who lost his left arm in an industrial accident. When asked the miracle question the client answered that he'd wake up with his left arm in place. Steve answered "Sure," and since he didn't know how to go on he waited. A long silence ensued and then the man added: "I guess you mean something that could happen," and Steve nodded. The man then went on to describe how he would get up and make breakfast with only one arm. There was never any talk again about getting the arm back.

It is obvious that many people with serious illnesses and handicaps wish they were well ("he'd wake up with his left arm in place") and there is no danger in them expressing this. When we acknowledge and validate ("Sure"), most people move to a realistic view (". . . I guess you mean something that could happen").

Clients know what's possible and what isn't. They know that talking with us won't give them back their arms, bring back the dead, or cure them or their loved ones of AIDS. Furthermore, it is important to recognize that ultimately the miracle question is

not so much about figuring out what would be a "dream come true" miracle for this person or family as it is about discovering, identifying, and replicating the tangible, observable effects of it.

Excerpted from *More Than Miracles* by S. de Shazer and Y. Dolan (2007). New York: Haworth Press.

Bill O'Hanlon's website can be found at http://www.brieftherapy.com/ and the title of a recent book is *Change 101: A Practical Guide to Creating Change in Life or Therapy* (2006). The two major professional organizations in SF Therapy are the European Brief Therapy Association (http://www.ebta.nu/index.html) created in 1994 and the Solution Focused Brief Therapy Association founded in the United States in 2002 (http://www.sfbta.org).

BASIC PHILOSOPHY

Solution-Focused (SF) therapists are serious optimists. They believe in the power of language to create and define reality, and therefore, that there are no absolute truths (de Shazer, 1994).

The dual influences of the MRI approach and Milton Erickson's work fused to produce a constructivist theory that proposes that humans create their realities, and if trouble develops, they can recreate them in ways that are more helpful to them. SF therapists emphasize the joint psychological construction of the therapy situation that allows therapists and clients to create new ways of viewing their lives and through these constructions formulate solutions to the problems clients bring to counseling. Approaching clients with the attitude that they have strengths and resources to solve their complaints, Solution-Focused counselors create an interaction designed to maximize client potential.

The SF therapist calls the client the "customer" and the problem the "complaint." In this way, the SF approach emphasizes that the client knows where he wants to go and is motivated to get there. The counselor is merely "hired" because she has some expertise in constructing solutions.

SF counseling's propositions are presented as countering the assumptions found in so-called traditional approaches to psychotherapy. For instance, whereas other approaches maintain that change is difficult, the SF theorists argue that change is constant. Other "myths" of traditional therapeutic approaches according to the SF theorists are presented in Box 14.2.

In beginning her work with Kelly, Mary, a Solution-Focused therapist, starts with the expectation that therapy will not take long and that Kelly can easily resolve his complaint. She is on the alert for Kelly's strengths and resources, and will surely note that he had the intelligence and persistence to complete a college degree. Mary approaches Kelly with the attitude that change is easy to achieve and that she would be surprised if Kelly did not change.

Box 14.2

Myths of "Traditional" Therapy

1. There are always deep, underlying causes for symptoms—client problems are symptoms of these causal factors.
2. Awareness or insight is necessary for change or symptom reduction—we must understand the cause of the symptom for people to get better.
3. Amelioration or removal of symptoms is useless or shallow at best and harmful or dangerous at worst.
4. Symptoms serve functions.
5. Clients are ambivalent about change and resistant to therapy.
6. Real change takes time; brief interventions are shallow and do not last.
7. Focus on identifying and correcting pathology and deficits. Traditional therapies look for pathology, the Solution-Focused therapist says "If you look, you will find it."

From O'Hanlon & Weiner-Davis (1989), pp. 26–30.

In countering the ideology of traditional approaches to psychotherapy, O'Hanlon and Weiner-Davis (1989) identified some important assumptions of Solution-Focused Therapy. These principles are as follows:

1. Clients have resources and strengths to resolve complaints.

The therapist's job is to help the client access these abilities and put them to work in the interest of solving the problem. Clients are often so focused on their difficulties that they forget about their strengths. It is essential that the Solution-Focused therapist remind them.

Kelly worries that his explosions of anger prove that he is out of control, that he is indeed an "angry person," and that his relationships will be destroyed if he does not change. His counselor Mary acknowledges Kelly's concerns, but she is also alert for Kelly's personal strengths and brings them to Kelly's attention. For instance, Mary commends Kelly for his sensitivity to and caring for others, which resulted in his coming to counseling. She asks Kelly about his work and comments on his ability to concentrate and focus on a task until it is completed to his satisfaction (rather than construing this process as "perfectionism"). Mary recognizes Kelly's desire to get tasks done well, including his motivation to improve his personal relationships.

2. Change is constant.

According to the SF philosophy, if one assumes that change is constant, one will behave as though change is inevitable. Basically, the Solution-Focused therapist conveys to the client verbally and nonverbally that she would be surprised if the problem persisted. O'Hanlon might add that clients must work hard not to change—see his 11 ways to stay stuck in Box 14.3 on page 470.

Mary presents with the attitude that she expects change and expects it soon. She asks Kelly about what his life will be like when he changes, not if he changes.

3. The SF therapist's job is to identify and amplify change.

In any approach to counseling, therapists create a reality with the client through the questions they ask and the things they choose to focus on or ignore. SF therapists identify what seems to be working, label it, and work on making it happen more often.

Kelly says that he argues with his parents about many things, from what football game to watch on Saturday afternoon to what his responsibilities and rights are within the household. However, there are times when he does not "blow up." Mary is quite interested in these exceptions to his patterns. Mary tries to find out how Kelly manages to avoid blowing up and asks him to do the same things in other situations.

4. It is usually unnecessary to know a great deal about the complaint to resolve it.

According to O'Hanlon and Weiner-Davis (1989), therapists can get stuck because they have "too much information about the complaint and too little information about the solution" (p. 38). Instead, SF therapists find out what clients are already doing that is working. Once the therapist and client have identified the characteristics of trouble-free times, the client can work toward doing these things all of the time.

Mary discovers that Kelly can often tell his girlfriend Janet when he is upset with her, which usually results in the two of them talking about a difficult issue and resolving it. Mary is not very interested in the particular issue involved, but more in how Kelly was able to approach the situation calmly rather than exploding. Kelly reveals that the solution to the situation is that he distracts himself for a few minutes before he approaches Janet. Mary immediately asks Kelly how he can do this in other situations, for instance, when conflict is impending with one of his parents.

5. It is not necessary to know the cause or function of a complaint to resolve it.

Going to the therapist is typically the last resort. Before they get to counseling, most clients have spent a lot of time trying to figure out what caused their problems because mainstream culture teaches that if we can find the cause, the solution will follow (O'Hanlon & Weiner-Davis, 1989). It is obvious to SF counselors that this rumination has not helped their customers. However, because we are brainwashed by society, the media, and therapists, our customers sometimes still ask the "expert" *why* they have the problem. A SF therapist might simply counter with "would it be enough if the problem were to disappear and you never understood why you had it?" (O'Hanlon & Weiner-Davis, 1989, p. 41).

Mary is not very interested in Kelly's personal history, nor would she spend much time delving into the history of the anger problems. In contrast, Kelly, who has been brainwashed by society, probably thinks that his anger problem is the result of some very complicated events way back in his childhood. No doubt his troublesome parents had something to do with it!

6. A small change is all that is necessary; a change in one part of the system can effect change in another part of the system.

A small, positive change raises our clients' confidence, and buoyed by the counselor's support, they begin to believe that they can create more changes. O'Hanlon and Weiner-Davis (1989) offered Milton Erickson's snowball metaphor of change as an illustration: once a snowball gets rolling down a hill, "the therapist merely needs to stay out of the way" (1989, p. 42).

A major goal for Mary is to find, in the first session, some small change Kelly could make that he would perceive as positive. For example, Kelly typically fights with his father over what football game to watch on Saturdays. Mary discovers that Janet likes football and usually agrees with Kelly about which games to watch. Mary asks if Kelly could ask Janet to bring over her portable television and join him and his father for the coming Saturday games. That way, Kelly could alternate between games. Not only might this change his relationship with Dad, but it might also enhance his partnership with Janet.

7. Clients define the goal.

Solution-Focused counselors dispute the idea that there is any one "correct" way to live (O'Hanlon & Weiner-Davis, 1985). Refusing to believe that there is some "real problem" that underlies the symptom leads Solution-Focused therapists to insist that clients determine the goals for treatment. The only exceptions to this rule are illegal or patently unrealistic goals.

Some therapists' first response to Kelly's situation might be to opine that he should move out of his parents' home. After all, he is 24 and employed. Shouldn't he be "mature enough" to live on his own? As an SF counselor, Mary joins with Kelly in his desire to find a solution for his problems with anger, implicitly acknowledging that it is his valid choice to remain in his parents' home.

8. Rapid change or resolution of problems is possible.

The first session is considered particularly powerful in the SF approach. Through reconstructing their views of their situations along with the counselor, clients typically see that they already know how to resolve the complaint. If the client still sees a need for change at the conclusion of the initial session, the counselor expects the client to go off and do whatever else is needed to create solutions before the next session.

During his first session with Mary, Kelly realizes that he has the negotiation skills necessary to avoid his outbursts of anger. After all, he is able to get along with his coworkers, and his relationship with Janet is not all that stormy. He need only apply these skills to his interactions with his parents.

9. There is no one "right" way to view things; different views may be just as valid and may fit the facts just as well.

Although many different views of a situation are valid, some are more helpful than others, according to the SF approach. When clients come to counseling, they are problem focused. Adopting a solution-oriented view is seen as more likely to produce change.

Our clients' views of problems often promote the "more of the same" syndrome (Watzlawick et al., 1974). Typically, if attempts to solve the problem don't work, the old adage "if at first you don't succeed . . ." seems to apply, and clients tend to "try try again" with the same strategies. SF theorists maintain that different views of the problem might lead to different strategies or even to defining the problem as not a problem! My client Jean's 9-year-old son developed a distressing tendency to tell his mother "I hate you" when she corrected his behavior. Jean's typical response was to lecture him about how this was an inappropriate thing to say. What she was doing had little effect on the young man's behavior, so we decided to have Jean stop doing more of the same and instead do something different—ignore these statements because he probably didn't mean them anyway. This strategy was apparently successful; the frequency of the "I hate yous" decreased. Further, when the boy did say this, the mother was not bothered by it any longer so she was much more relaxed in her interactions with him.

Kelly reports that he experiences his most troublesome outbursts when his parents "pick at him" and "treat him like a child." He views this behavior as controlling and evidence that his parents do not view him as an adult. When he gets angry, he is attempting to convince them of the "wrongness" of their actions, and when they have these talks, Kelly progressively raises the volume of his voice, trying to really get their attention. When the volume approach does not work, he will occasionally throw something. However, Kelly's angry outbursts are not working to change his parents' behaviors, and Kelly begins to realize that his own behavior is, in fact, rather childlike. Mary sees Kelly's escalation as "more of the same" and attempts to get him to do something, anything, different the next time conflict looms with his parents. She might also try to portray Kelly as "sensitive" rather than "easily offended" or "defensive."

10. Focus on what is possible and changeable rather than on what is impossible and intractable.

The complaints that SF therapists and their clients address are those that are amenable to change.

Mary would never attempt "personality reconstruction," but she might attempt to help Kelly have fewer angry outbursts.

HUMAN MOTIVATION

Hard-core SF therapists really don't care what motivates people in general. They simply observe what clients want to achieve and use clients' identified strengths and resources to help them reach solutions.

Even so, O'Hanlon (2006) distinguishes between positive and negative motivation, and further, past, present, and future motivation. Positive and negative motivation refer to our tendencies to move toward things we want and away from those we wish to avoid. In O'Hanlon's view, our behavior can be informed by each of these in the moment, or by experiences/expectations of them in past or future. He provides an example of a young man who was negative past motivated (in O'Hanlon's terminology) by the assertion of his high school counselor that he was not "college material" (2006, p. 3). The young man ended up with a Ph.D.!

CENTRAL CONSTRUCTS

EXCEPTIONS

An SF therapist starts with the basic assumption that regardless of the severity of a client's presenting problem, there are always times when the problem does not happen. The SF counselor takes the stance that she would be very surprised if there were not exceptions to the complaint. The motivation behind this belief is to help clients to see that the complaint is not always present and that they already are successful and happy at times. The therapist works with the client to find ways to increase those activities that have produced the exceptions.

Invariably, clients have not paid attention to exceptions. Clients are often quite surprised when the therapist focuses on the times that are trouble-free rather than on the presenting complaint. They are used to thinking about the complaint, and they typically have been exposed to (some would say indoctrinated by) the traditional models of psychotherapy that spend a lot of time on how and why the problem occurs.

Kelly's therapist, Mary, will be hard at work from the beginning of the first session to find exceptions to his "angry personality," which they have since redefined as troubles in expressing anger and negotiating conflict. She will be likely to ask him about when he has disagreed with his parents but not had an angry explosion, and what he did to manage to avoid it. Kelly has invested a lot of effort in trying to figure out why he is so "angry" with little result. When Mary encourages him to think of times when he isn't angry or can negotiate agreement with someone, he is pleasantly surprised and even smiles in response to her questions.

CHANGE TALK

The goal of an SF interview is to talk about the client's problem in ways that bring about change (de Shazer, 1989). Complaints are discussed in terms of specific behaviors amenable to change rather than using negatively valenced labels. Use of the presumptive terms in place of probabilistic language (such as *when* rather than *if*) in talking about change emphasizes that the counselor firmly expects change to occur (Corcoran, 2005). For example, the therapist can ask the client "when you (perform the exception) what do things look like?"

Discussions with Mary about times when he is not angry (i.e., when he is happy and content) help Kelly construct a situation in which it is acknowledged that anger is transient, not a personality trait fixed at birth. Relabeling the "angry personality" as difficulties in communicating (or perhaps temper tantrums) suggests that the troubles will be easy to banish. Mary asks Kelly "When you communicate well, how would you describe your relationship with your mother?"

SOLUTIONS

Solution-Focused counselors believe that if we "accept the client's complaint as the reason for starting therapy, therapists should, by the same logic, accept the client's statement of

satisfactory improvement as the reason for terminating therapy" (de Shazer, 1991, p. 57). Rather than focusing on the client's complaints, SF counseling concentrates on what would be perceived by the client as an acceptable solution to the problem—a difference that would make a difference.

Kelly, by his report, wants to deal with his problems with anger. Mary, accepting Kelly's goals, helps him to identify times when he negotiates conflict satisfactorily and works with him to decide how to do this more often.

Strengths and Resources

The aspiring SF counselor needs to adopt a special view of people. Rather than looking for their weaknesses (because if you look under every rock for pathology, you'll certainly find it), the SF therapist emphasizes the strengths of clients and the resources they already can access. These qualities are put to work finding the solutions to complaints.

Cade and O'Hanlon (1993, p. 138) related the story of a client who was known for her work training difficult horses. After asking her to elaborate how she did so well with these beasts, the therapist asked if these principles could be applied to dealing with her troubles with her husband!

Mary works hard to identify and emphasize Kelly's strengths and the skills he can use in the service of reaching his preferred solution. She discovers that he is bright and likes to solve puzzles. He clearly is good at attending to detail and has the ability to concentrate intensely.

THEORY OF THE PERSON AND DEVELOPMENT OF THE INDIVIDUAL

SF advocates do not postulate a theory of the individual or of dysfunction. This theory is more a theory of counseling than a theory of human nature. A Solution-Focused therapist does not care where the problem comes from and is not very interested in the history of the individual or of the problem except in special, very rare, circumstances. For example, in discussing one of the most difficult problems therapists confront, severe psychological dysfunction such as schizophrenia, O'Hanlon and Rowen (2003) note that "when some medications were found to be helpful in managing the symptoms of such disorders, it was hailed as proof that the disorders had a biological basis. This is akin to arguing that if you take cocaine and it helps lift your depression, you have a biological disorder involving cocaine deficiency" (p. 19). Acknowledging that the jury is still out about the origins of these dysfunctions, O'Hanlon and Rowen advocate that SF techniques can be helpful if the therapist maintains an awareness of neurological and biochemical influences that wax and wane in these presentations.

Mary spends no time wondering about any personality theory or factors in Kelly's childhood. Such factors are just not relevant to the kind of counseling she offers.

HEALTH AND DYSFUNCTION

The diagnosis in Solution-Focused Therapy is as follows: a customer has come with a complaint. SF therapists are not concerned with notions of health or dysfunction—they simply listen to the client's construction of the problem, look for exceptions, and construct solutions. The client determines what is healthy; that is, the customer determines the goals of therapy. Therapists who think that their personal version of the problem (e.g., its causes and meaning) is the only correct one are suffering from "delusions of certainty or theory countertransference" (Hudson & O'Hanlon, 1991).

Despite the emphasis on listening to each client as an individual, the SF therapist could also say that "all complaints are alike. In almost all cases, the client's complaint includes wanting the absence of something without having any idea about what a reasonable replacement might be" (de Shazer, 1988, p. 52). Often, the therapist helps the client redefine the complaint in solution-oriented terms, a process called reframing (de Shazer, 1991).

Another way of looking at dysfunction is that clients are stuck. O'Hanlon (2006) has some ideas about this, which you can read about in Box 14.3.

In Kelly's case, he wants to lose the temper tantrums, but has not decided how to behave instead of having fits. Kelly comes to Mary thinking that he needs to get rid of his angry and compulsive personality. Alternatively, he could think that Mary needs to help him figure out ways to change those around him, particularly his parents. Mary acknowledges these ideas, but will then proceed to help Kelly redefine the complaint in a way that leads to solutions.

Box 14.3

How NOT to Change

Eleven Strategies for Staying Stuck

1. Don't listen to anybody.
2. Listen to everybody.
3. Endlessly analyze and don't make any changes.
4. Blame others for your actions or problems.
5. Blame yourself or put yourself down regularly.
6. Keep doing the same thing that doesn't work.
7. Keep focusing on the same things when that focus doesn't help.
8. Keep thinking the same thoughts when those thoughts don't help.
9. Keep putting yourself in the same unhelpful environment.
10. Keep relating to the same unhelpful people.
11. Put more importance on being right than on changing.

From *Change 101* by B. O'Hanlon (2006), p. 162. Used with permission.

NATURE OF THERAPY

ASSESSMENT

SF advocates do not believe in traditional assessment; they would say that assessing the client belongs in the medical, problem-focused approach to counseling. Instead, SF counselors *interview for solutions* from the very start of counseling (DeJong & Berg, 2002).

Mary asks lots of questions of Kelly, but they are focused on the exceptions to his complaints of angry outbursts ("disagreements with his parents") and his strengths and resources.

OVERVIEW OF THE THERAPEUTIC ATMOSPHERE

Therapists at the Milwaukee BFTC use a team-assisted approach to counseling similar to that used by family systems therapists, although Nunnally and colleagues (1986) reported that the groups developed the procedures independently. Counselors typically work with a team of consultant therapists, who are usually behind a one-way mirror. Often, sessions are videotaped as well. Sometime during the session (normally toward the end), the therapist takes a break to consult with the team and normally returns with some compliments for the client and a homework task to be completed between sessions. The team, along with the therapist, is seen as an integral part of the psychotherapy system (de Shazer, 1991).

Typically, clients in Solution-Focused Therapy complete four to five sessions, and most find their solutions in fewer than 10 sessions. Sometimes, clients attend only a single session of counseling and emerge as satisfied customers.

SF Therapy is seen as a collaborative venture (Guterman, 2006). The therapist's task in the first session is to establish a working, cooperating relationship with the client, a process de Shazer calls "developing fit" (1988, p. 90). In establishing the relationship, the therapist invites client cooperation by initiating cooperating behaviors. Clients will then reciprocate by demonstrating their versions of cooperating behaviors.

The relationship in SF counseling is described as having a special kind of intimacy and harmony. Counselor and client pay attention to what the other says and respect each other's worldviews as valid and meaningful (de Shazer, 1988). De Shazer and Dolan (2007) write that SF therapists "almost never pass judgments about their clients, and avoid making any interpretations about the meanings behind their wants, needs, or behaviors. The therapist's role is viewed as trying to expand rather than limit options" (p. 4).

O'Hanlon and Weiner-Davis (1989) pointed out that language can be used to help establish the therapeutic relationship. Initially, SF therapists are likely to adopt some of the client's language as a way to join the client. The SF therapist then gently helps the client channel the language used about the complaint into more solution-oriented forms (i.e., change and exception talk).

Berg and Shafer (2004), in writing about working with clients mandated to treatment, summarized the SF approach to cooperating in the following way:

> Cooperating with clients means learning how to stand side by side with them, not facing against them, as in a competition . . . we see things from clients' perspectives and eliminate the "professional posture" of judging them. Clients do not need one more failure or one more label as "incompetent" or "difficult." The most important contribution a

practitioner can make during the initial contact is to shape clients' experience in a way that is different from any other negative professional experiences they may have encountered in the past. Clients need the opportunity and the latitude to make choices instead of feeling coerced to comply; to feel understood instead of being labeled" (p. 90, quotes in original).

Mary adopts Kelly's language of "angry person" to begin with, so that he feels at ease in the first session. Kelly, of course, is a little tentative at first because he is afraid that Mary will see him as childish and reject his version of the problem. Mary joins Kelly in his frustration and comments on how he is very sensitive to others, which is demonstrated by his sadness after he has a fight with his parents or Janet.

Roles of Client and Counselor

The SF counselor is expected to take responsibility for what happens in sessions. SF therapists have special knowledge about how problems are maintained and changed. In this sense, the therapist is an expert in change, but not about the client's particular problem. Clients have all the necessary knowledge about their particular complaints along with the ability to change things. The therapist focuses on the text (what the client says needs to be different) without making any further assumptions (de Shazer, 1994).

SF counseling is an energetic process, with the therapist taking the lead and using a series of questions designed to elicit information relevant to exceptions and solutions. The client is seen as an active collaborator in this process and as responsible for doing whatever is necessary to solve the problem.

de Shazer (1988) identified three types of clients: visitors, complainants, and customers. *Visitors* are clients who don't have any complaints. They are often in the counselor's office because someone else has told them to be there. In fact, in the case of visitors, de Shazer pointed out that the real client is probably not in the office. Thinking about the client as "visiting" rather than "involuntary" avoids creating an "involuntary" therapist. An involuntary client paired with an involuntary therapist is a recipe for trouble. According to de Shazer, the way to deal with a "visitor" is to be nice, be on his side, focus on what works, and give compliments.

Complainants are signaling that therapy can begin. No matter how diffuse, vague, or confusing the problem, at least there is a problem! The complainant has come with some expectation that change will happen as a result of therapy. I once had a client, Sue, who came to therapy because she was depressed. How did she know she was depressed? She found herself tearing up at Kodak commercials. No other symptoms of "depression" were reported. I never really did decide whether she was a visitor or complainant, and I am sad to say that our work together was not successful, at least by my standards.

Clients who bring a complaint and the desire to do something about it are called *customers*. Ideal clients for any therapist, these individuals can be given tasks to complete with the expectation that they will oblige.

De Jong and Berg (2007) note that the distinction between visitors, complainants, and customers, although helpful to understand, is not currently used all that often. They contend that it is simply more respectful and helpful to assess the extent to which clients have clarified their goals as a way of assessing, rather than placing them in formal categories.

Mary is quite active in her sessions with Kelly and confidently accepts her job as an expert in change. Kelly appears to be a customer in his presentation to Mary because he indicates a problem and a desire to change. Mary expects Kelly to be a collaborator in the change process and to work hard to make solutions happen. If Kelly had been coerced into therapy by his parents or Janet, his girlfriend, the situation might be very different. He might then be a visitor. If Kelly were a visitor, Mary would empathize with his difficult situation, but not be inclined to go further.

GOALS

Berg and Shafer note that "SFT begins with finding out what the *client* wants" (2004, p. 85; italics in the original). The counselor works with the client to develop the specific, attainable, and concrete goals that are essential in SF Therapy. These goals should be observable. As noted earlier, even very small changes lead to more change, so no reasonable objective should be dismissed as trivial. Often the counselor will ask the client, "What will be the first sign of change?" This question searches for the smallest increment of change that is meaningful to the client.

Regardless of the complaint, the goals of the good SF therapist are as follows:

1. Change the *doing* of the situation that is perceived as problematic
2. Change the *viewing* of the situation
3. Evoke *resources, strengths, and solutions* to bring to the situation perceived as problematic (O'Hanlon & Weiner-Davis, 1989, p. 126)

The SF counselor is wary of "absence" goals (Cade & O'Hanlon, 1993; de Shazer, 1988)—that is, goals that specify that something will go away but do not specify what fills the vacuum. The best goals are those that specify what replaces the unwanted behaviors.

When asked what he wants to get out of therapy, Kelly says that he wants to stop being an angry person. He also wants to be less perfectionistic. He mentions "not yelling" or "not flying out of the house in a fury" or "not throwing any object within reach." Mary notes that these are "absence goals" and begins to look for the behaviors that sometimes replace the yelling ones.

Mary asks Kelly if it would make sense to focus on how he will have discussions at normal volume with his parents. He could learn some negotiation skills. Kelly says that he'd like to be more easygoing overall, which might lead to being able to relax at work, too. Mary asks Kelly how he will know he is more easygoing. What will be the first sign?

PROCESS OF THERAPY

Solution-Focused counselors want action, and right away! The very first and most critical task of counseling is defining (actually redefining) the problem. Client and counselor negotiate the nature and meaning of the client's complaint (Guterman, 2006). For example, a client would be asked, "What do you mean by 'depressed'?" or more likely, "What is it like when you are not depressed?" Adopting the client's lingo, so to speak, is a way the SF therapist enters the client's world and joins with him in constructing the therapeutic relationship.

Once the therapeutic relationship is established, the counselor will gradually begin to use change talk, suggesting words that have less negative connotations than those typically

used by the client, and that also imply change rather than a static state of affairs. A "speech phobic" client might be termed "nervous," or a depressed client "sad." Most important, the SF counselor is trying to change labels to specific descriptions of behavior that are more amenable to change.

SF counselors focus on the present, not the past. Even though clients often think that a detailed exploration of the past is necessary to progress, SF counselors think that there is a risk of becoming bogged down in problem talk if there is too much focus on the past. They tend to treat historical information only as a source of possible solutions (Rossiter, 2000).

Solution-Focused therapists have proclaimed the death of client resistance (actually, they admit to murdering it in cold blood; de Shazer, 1998, p. 5) and have reportedly had a funeral for it (Cade & O'Hanlon, 1993). de Shazer noted, "when the therapist focuses on what it is exactly that the client wants and lets that be the guide, there is no need for a concept of 'resistance'" (1994, p. 61, quotes in original).

SF counselors don't recognize transference and countertransference in the way that many other theoretical approaches do. However, they do identify "theory countertransference," which is the therapist's tendency to get carried away and see everything through the lens of her pet theory (O'Hanlon & Rowan, 2003).

Solution-Focused counselors place great emphasis on the first session of therapy (Guterman, 2006). At the start of the session, the SF therapist will take some time to join with the client, chitchatting about things that have nothing to do with the problem. However, very quickly the counselor moves into working with the client to reconstruct the problem or what Guterman (2006) calls "coconstructing a problem and goal" (p. 46). First, the counselor will ask for a brief description of the problem but immediately follow with series of questions designed to extract information about exceptions to the problem—times when things are progressing smoothly, past solutions to the current problem, and the person's strengths and resources. Box 14.4 shows a list of questions offered by O'Hanlon and Weiner-Davis (1989). The SF therapist is aware of, and asks about, pretreatment change (i.e., change between the time the client called for an appointment and the appointment).

The initial goal of the first session is to create a solvable complaint, at the very least, and at best, to solve the problem. In difficult cases, the SF therapist seeks to introduce uncertainty about the problem; that is, to somehow raise questions about the client's construction of the complaint (de Shazer, 1988). "Therapeutic misunderstanding" of the client's story is often used by the counselor to loosen the certainty with which the client holds his view of the problem. For example, a client might report that he is "compulsive." The SF counselor might wonder if this is really a time management problem because the client finds himself working too many hours.

The remainder of the first session is devoted to finding exceptions to the complaint and exploring these; the counselor and client construct concrete, solvable goals and then look at ways to reach these goals. At the end of the session, the counselor typically gives the client a solution-relevant task to complete over the interval between sessions, which can range from a week to months.

In the remaining sessions of counseling, the counselor wants to use the "more of the same" principle to her advantage—continuing to do what works and abandoning what doesn't. Sessions begin with checking the results of homework assignments. Counselors ask clients about what happened over the interval that they'd like to continue.

Box 14.4

A Series of Solution-Focused Questions

1. What is different about the times when _____ (the exception happens)?
2. How did you get that to happen?
3. How does it make your day go differently when _____ (the exception happens)?
4. Who else noticed that _____ (exception)? In what way could you tell that she/he noticed? What did he/she do or say?
5. How did you get her/him to stop _____ ?
6. How is that different from the way you might have handled it _____ (one week, one month, etc.) ago?
7. What do you do for fun? What are your hobbies or interests?
8. Have you ever had this difficulty in the past? How did you resolve it then? What would you need to do to get that to happen again?

Once clients tell what was good in the interval between sessions, the counselor responds with past-tense questions about these positives. Examples of these questions might be: How did you get that to happen? How did it (the positive change) make your day go differently? The SF counselor wants to talk about the good things that happened for the entire session, if possible (and sometimes it is). Although the SF theorists would argue that many clients accomplish what they need very quickly (i.e., in one session), O'Hanlon and Weiner-Davis (1989) identified three groups of clients:

1. The miracle group (one-session cure)
2. The so-so group (report having a better week but are not convinced that the problem is completely solved)
3. The same or worse group (pp. 147–151)

Working with the *miracle* client is easy—the counselor simply focuses on the change and maintaining it. Clients are asked to think about factors that could lead to setbacks. Plans can then be made to defeat these. Sometimes clients are skeptical that change will last; they have seen improvement in the problem before that did not last long. The SF therapist respects this healthy caution rather than seeing it as resistance and helps the client explore previous patterns. The counselor then asks the client to specify a short period of time of change in the problem that would really make a difference. SF therapists do not generally prescribe relapses, but if setback seems likely, then ups and downs are conceptualized as part of the normal process of solving the complaint. At the end of the session, the counselor asks the client if he would like to schedule another session. A "check-up" session is scheduled with most clients.

Dealing with the *so-so* group is a little trickier. These clients respond to questions about what good things happened with a description of the difficulties they encountered.

According to O'Hanlon and Weiner-Davis, the counselor should immediately interrupt the client to refocus on positives. The client should always be assured that the difficulties will be discussed later in the session.

After the positives are exhausted, solution-oriented procedures are then used to work on the difficulties the client reports. Exceptions are sought, and sometimes scaling questions are used (see the section on techniques).

The *same or worse* clients, of course, are the toughest customers. The wise SF therapist never accepts these negative reports automatically. Closer examination often reveals the small change needed to alter the client's perception of his first session outcome. My clients Susan and George came to their first session struggling so mightily with their relationship that they described themselves as "not a couple." At the start of the second session, they characterized their week as no better than previous ones, but I soon discovered that they had spent more time together during the week and had even gone out for a special dinner over the weekend. These behaviors certainly seemed more like a couple to me.

Same or worse clients sometimes truly see the problem as persisting. SF theorists advise that when that happens, the therapist should ask two sets of basic questions:

1. Who is our customer? Who is complaining? Who wants to see change?
2. What is the goal? How will we know when we've gotten there? (O'Hanlon & Weiner-Davis, 1989, p. 152)

Sometimes these questions will reveal that the real customer is not in the session.

A final caution. Searching for strengths and solutions can sometimes be "more of the same." As with any therapeutic approach, rigid or dogmatic behavior on the part of the therapist can be detrimental to client progress. Sometimes it's possible to get carried away with searching for strengths and solutions—clients may just have a hard time seeing it that way. Particularly with same or worse clients, it may also be helpful to consider that the therapist and therapy may be part of the problem rather than part of the solution. Solution-Focused counselors who persist in the strengths/solutions approach in these circumstances are simply doing more of the same. O'Hanlon and Weiner-Davis suggested that in this situation, it might be wiser to resort to exploring the complaint pattern, or occasionally, to get pessimistic, such as when a warring couple is asked how in the heck they manage to stay together. Taking a pessimistic stance is considered a last-ditch tactic (Corcoran, 2005).

Mary is aware that redefining the problem is her first task. She asks Kelly to relate situations in which his "attention to detail" is not a problem or even when it is helpful. They explore situations in which he is able to contain his anger, or more simply, when he does not yell or throw things. When Kelly talks about his parents "pissing him off" or treating him like a child, Mary asks, "What is happening when you aren't pissed off? What is happening when they treat you like an adult? When you are able to negotiate differences with your parents without yelling, what is different?"

THERAPEUTIC TECHNIQUES

SF Therapy has numerous techniques, many of which are designed so that they can be adapted to a wide range of complaints. However, the therapist has to really pay attention

to what she is doing because "technique" in SF Therapy can be as subtle as how you word a question to a client. A very general strategy in SF counseling is to identify exceptions and then encourage the client to do more of the same (Guterman, 2006).

Questions

Solution-Focused counselors rely heavily on questioning the client. A special SF tactic is the *presuppositional question*, which gives the respondent few options. A classic presuppositional question is when the attorney asks the client, "Have you stopped beating your wife?" (O'Hanlon & Weiner-Davis, 1989, p. 80). In SF Therapy, presuppositional questions are used to emphasize change possibilities and the strengths of the client. For example, the classic SF question is, "When the problem is not present, how are things different?" Notice that the phrasing is not "*if* the problem were not present." The good presuppositional question already assumes that success happens. Presuppositional questions are open ended, but do not leave room for negative answers.

Pichot and Dolan (2003) identified several types of questions used by SF therapists. Some of these are discussed next (the Miracle and Scaling questions). Others are *difference* (e.g., what difference did it make for you to say good morning to your daughter every day this week?), and *relationship* (e.g., how will your husband know when you are no longer depressed?) questions. In general, when questions are used, they are usually followed with more questions intended to elaborate on details, thus making the solution more vivid for client and counselor.

Mary has used a number of presuppositional questions with Kelly, such as, What is going on when your parents treat you like an adult? What happens? What difference does that make in your relationship to your mother? Your father?

Normalizing the Problem

This technique helps clients feel as though they are not "crazy" or extreme in their situations. One way to normalize is to ask clients, "How can you tell the difference between [the stated problem] and [a normalized explanation of it]? (O'Hanlon & Weiner-Davis, 1989, p. 97). Normalizing compliments are a special case of normalizing the problem and usually take the form of commending the client for his or her strength in handling a very difficult situation.

Mary asks Kelly how he knows the difference between his parents treating him like a child and their expressing their caring for him. She also tells Kelly, "Given the circumstances, I am very impressed with how often you do keep your cool. It's kind of tough to grow out of being the kid, huh?"

Compliments

People love compliments! Counselors should keep this in mind and comment on the great things clients are doing at any opportunity (De Jong & Berg, 2007). Reframing, or positive connotation, is a particularly helpful way of complimenting clients. For instance, when one member of a couple is very vigilant, the therapist can choose to see this behavior as "paying attention to what is going on in the relationship." One other good way of

complimenting clients is to point to things that they have already done toward a solution. De Jong and Berg (2007) note that clients often self-compliment; the therapist should notice and reinforce these. However, it is important in all of these cases that the compliments be real (not used just to cheerlead) and based squarely in information provided by the client.

Mary congratulates Kelly on his success in dealing with situations in which he gets into conflict with his girlfriend, Janet. He is also sensitive to relationships and cares a lot for other people. In fact, he cares so much that he came to counseling!

Miracle Question

A trademark technique in SF Therapy is the miracle question (Berg, 2005). Designed to help clients figure out what they want from therapy without having to spend a lot of time contemplating problems and their causes, the miracle question goes something like this: "Suppose that one night, while you were asleep, there was a miracle and this problem was solved. How would you know? What would be different?" (de Shazer, 1988, p. 5). de Shazer and Dolan (2007) note that the miracle question can have several functions in SF counseling: to help clients figure out their goals for Therapy, for one. They also contend that asking the miracle question helps clients get a sense that parts of the solution are already happening—the detailed questions that are used to follow up invariably get to things that have happened in the client's life that are related to the miracle. Typically, the miracle question is followed with a scaling question (see the following section) that asks the client where they are now on a 1–10 scale ranging from 0 (just decided to go to the counselor) to 10 (the miracle is accomplished; de Shazer & Dolan (2007).

Mary asks Kelly this question in the hope that he can generate some concrete indicators of how he will know when the problem is solved. Mary would also like to know how Kelly's parents (or Janet) will know when Kelly is different.

Scaling Questions

Scaling questions can be used in several ways. The most common is, "On a scale from 0 to 10, with 0 being the worst the problem has ever been and 10 being the problem is completely solved, where are you today?" (Cade & O'Hanlon, 1993; de Shazer, 1988, 1994). Note that the question stacks the deck in the counselor's favor because it is fairly unlikely that the problem is at its absolute worst when the client is in the session.

Once clients give a number on the scale, they are often asked, "What one or two things could you do this week to bring you up two points?" Alternately, they can be given homework, such as keeping track of all the seven or eight things that happen between sessions. Scaling questions can also be used as confidence builders by setting the anchors as 0 representing absolutely no confidence that the complaint will be solved and 10 absolute certainty that it will be (Cade & O'Hanlon, 1993).

Mary asks Kelly to rate his anger on a 1 to 10 scale. He says that it is a 6. When asked what one thing he could do this week to bring himself up to a 7, Kelly thinks for a while.

Finally, he says that he could count to 10 before he answers any questions that his mother or father asks.

Prediction Tasks

Prediction tasks are often used when exceptions to the problem seem random (de Shazer, 1988). Clients are asked to stop sometime during their day—for example, before they go to sleep at night—and predict whether the problem or exception will occur the next day.

If Kelly could not identify circumstances in which he felt like a laid-back guy (i.e., was more patient with others), he might be asked to predict each night whether he would have that feeling the next day. He would be asked to track the accuracy of his predictions.

Fast-Forward Questions

Fast-forward questions can be used when clients absolutely cannot think of exceptions (O'Hanlon & Weiner-Davis, 1989). The counselor then asks them to mentally project themselves into a future in which the problem does not exist. Because of the speculative nature of this question, a great deal of time must be devoted to getting the client to be specific (asking such things as, "How will your life be different?" "Who will be the first to notice?" "What will he or she do or say?" and "How will you respond?").

Mary sends Kelly to 2 years from now and asks him to describe his laid-back self. Kelly says that he is able to negotiate with his parents. He reports that he helps folks at work with things that are important to him and is able to relax about the rest of the stuff. Mary is quite pleased with this view of Kelly's future.

Asking about the Problem

Exploring the problem is a last-ditch effort used when the client can't think of exceptions (O'Hanlon & Weiner-Davis, 1989). This tactic is typically used to find a pattern in the complaint that can be altered (remember, a small change is a great place to start).

The therapist asks detailed, specific questions in attempting to elicit the exact sequence of events in the problem chain. This inquiry is *not* intended, of course, to elicit causes or any such nonsense, but to document the exact problem sequence so that a small change can be suggested that will hopefully lead to larger change. Also, because the "more of the same" principle suggests that problems are maintained by people's faulty change attempts, information is needed about these to reverse them.

Because Kelly is responding so positively to solution talk and readily finding exceptions, Mary feels no great need to ask a lot about the problem.

Externalizing

Drawing from White and Epston's work (1990), O'Hanlon and Rowan (2003) suggest that giving the problem a name and placing it outside of the client can be helpful. You can read much more about this technique in Chapter 15 on Narrative Therapy.

Mary and Kelly decide that Temper has gotten the best of Kelly in the past. It is now time for Kelly to look at ways in which he has defeated Temper and put it in its place.

First Session Formula Task

"Between now and the next time we meet, I would like you to observe, so that you can describe to me what happens in your (pick one: family, life, marriage, relationship) that you want to continue to have happen" (de Shazer, 1985, p. 137). Although not a presuppositional question, this task makes use of the assumption that something good is already happening in the client's life. Clients, who are often very obsessed with what's wrong, are startled when the therapist asks them what's right. According to O'Hanlon and Weiner-Davis (1989), clients often do something new, different, and good in response to this task, even though it requests no change.

Mary assigns Kelly the first session formula task, and he comes back with a list of things he likes about his life. He is happy with his relationship with Janet and mostly likes his work. Mary asks what he likes about his relationship with Janet; she is setting him up for a generic task.

Generic Task

Once goals have been established, the client can be asked to keep track of what he is doing this week that _____ [makes him feel more in control, makes him less stressed, and so forth] (O'Hanlon & Weiner-Davis, 1989). The idea is to fill in the blank with the exception situation. A variant of this task that works particularly well with addictive or compulsive processes is the "pay attention to what you do when you overcome the urge to _____" assignment.

Kelly reports feeling tense much of the time, which seems to make it easier for him to lose his temper. As part of reframing Kelly's problem, Mary and he decide that he needs to be more relaxed. Mary therefore gives Kelly the assignment of keeping track of what he does during the week that makes him more relaxed.

Breaking Patterns

Almost anything that changes the pattern of the complaint can be helpful. O'Hanlon (O'Hanlon, 2006, pp. 57–90; O'Hanlon & Weiner-Davis, 1989, pp. 130–132) suggests some ways of interrupting the sequence. Examples of these tactics include the following:

Changing any body behavior associated with the pattern. O'Hanlon (2006) reports directing overeaters to eat with the wrong hand (i.e., the nondominant one). I am sure this would raise my awareness as I clumsily spilled food on my lap.

Changing timing or duration of the pattern. For example, couples can be asked to fight from 6:00 to 6:17 A.M. every day (see the discussion of structured fights). A person who is anxious about giving a speech could be asked to be anxious 2 hours before the speech and get it over with. Client Denise compulsively checks doors 10 times before she goes to bed (to see if she has locked them). She could be asked to check the doors 25 times instead of 10.

Changing the location of the pattern's performance. O'Hanlon (2006) offered a particularly amusing example of changing the location. A couple reported having nasty fights. They were instructed to go immediately into their bathroom the moment they begin to argue. The husband was told to undress and lie in the bathtub while the wife sits fully clothed on the toilet. The couple was instructed to continue the fight. When they tried to follow the therapist's orders, of course they couldn't and broke into laughter. After that incident the couple found themselves looking toward their bathroom and laughing whenever a discussion started to get tense.

Adding at least one new element to the complaint pattern. A client trying to quit smoking would be instructed to place his cigarettes in some difficult-to-reach place (a neighbor's mailbox, for instance). O'Hanlon (2006) describes having a client put on her most favorite shoes before she allowed herself to binge.

Linking the complaint performance to the performance of some burdensome activity. This technique resembles Haley's (1963) benevolent ordeal. One of my clients was having trouble falling asleep at night because he was ruminating on angry thoughts. Because he had occasionally lamented that his garage needed cleaning and he hated that task, I told him that if he did not sleep within 20 minutes of hitting the bed, he was to get up and clean the garage. After all, he might as well use his nonsleeping time productively. At his next session he reported absolutely no problems falling asleep over the preceding week!

Changing the context of the complaint. A client having trouble eating sufficiently (notice that she was not characterized as anorexic!) who normally eats alone could be instructed to always eat in the presence of others.

Change the clothing worn during the pattern. Watch out if I am wearing purple! It means that I am in a bad mood. I should probably wear green instead.

Mary decides on an ordeal task for Kelly to alter the performance of his temper outbursts. Kelly, who does not like to write about his personal experiences, is asked to write down everything he wants to say to his parents before he tells them about it. The minute he begins to be annoyed with something they've said, he is to go directly to his room, sit at his desk, and write out his complaints. He can then give this written summary to his parents.

Surprise Task

This assignment is often used with couples or families and directs clients to do one or two things that will surprise family members or partners. Clients are instructed as follows: "Do at least one or two things that will surprise your parents (partner). Don't tell them what it is. Parents (partner), your job is to see if you can tell what it is that she/he is doing. Don't compare notes; we will do that next session" (O'Hanlon & Weiner-Davis, 1989, p. 137). If the target person is a young child, the rest of the family can be asked to leave the room while the counselor coaches the child on strategies that he can use to stump the family (Reiter, 2004).

No one says that therapy can't be fun sometimes! Clients who really engage in this task generally enjoy it. They become solution-focused detectives (i.e., searching for good things, not bad). At the least, this task can introduce change into patterns of interaction in a positive way. Sometimes the surprises even turn into solutions.

Mary wonders what might happen if she could get Kelly's folks into counseling and give them the surprise task. When Kelly and his parents return for the next session, she would not ask them what they did for the other. Instead, she would ask Kelly what he detected that his father did and vice versa. Mom would be asked the same question about Kelly and Dad. Sometimes this process results in giving credit to the other for things they didn't do intentionally, such as when Kelly praises Mom for cooking his favorite vegetable—boiled carrots. Mom secretly thinks, "I thought he hated boiled carrots," but is gracious in accepting Kelly's appreciation.

Write, Read, and Burn

This task is useful for obsessive or depressive thinking (de Shazer, 1985). The client is instructed to write about the problem on even-numbered days for a specified period of time, even if he only has a few sentences to write. On odd days, the client is to read the notes and then burn them. Between writing, reading, and burning, the client is to put off thinking about the problem until the regularly scheduled time.

As de Shazer noted, this task literally makes the client's troubles go up in smoke (p. 121)! Also, write, read, and burn helps clients achieve distance from their concerns and become more objective. Most clients find that after a few days they have better things to do than to dwell on the problem.

On even days, Mary tells Kelly to make a long list of things his parents do that make him mad. On odd days he is to burn his lists after reading them over.

Structured Fight

This technique is a version of changing the pattern of the complaint often used with couples. The SF counselor instructs the clients to fight in the following way: (a) Toss a coin to decide who goes first. (b) The winner gets to bitch for 10 uninterrupted minutes. (c) The other gets 10 minutes. (d) There must be 10 minutes of silence before tossing the coin again (de Shazer, 1985).

Kelly could invite his parents to argue with him three times in the next week. They follow the 10-minute sequence, each of them complaining and listening. If they are not finished after one round, they wait 10 minutes and repeat the process.

Do Something Different

Designed to disrupt the "more of the same" syndrome that maintains problems, this task is often used when one person is complaining about the behavior of another person and has tried "everything" to get the other to change, to no avail (de Shazer, 1985).

Mary tells Kelly to do something different the next time he is headed for an argument with his parents. He takes her advice, and the next time he senses that his parents are going to criticize him, he breaks into a dance, skipping around the living room. His parents collapse in laughter.

SOLUTION-ORIENTED HYPNOSIS

In contrast to traditional uses of hypnosis, the SF therapist uses it to summon skills that support solutions. This unique approach to hypnosis apparently originated with therapists of the "Ericksonian" school who used it to "access unconscious resources" (O'Hanlon & Weiner-Davis, 1989, p. 139). The implication is that the resources evoked are those that are thought to be beyond the client's conscious control.

Mary hypnotizes Kelly and asks him to see himself responding to his parents calmly. He sees himself doing so and even cracking jokes about how they care so much about him that he can't stand it.

EVALUATION OF THE THEORY

Solution-Focused Therapy is a relative newcomer to the psychotherapy scene. These authors are prolific, fun to read, and, for the most part, very good at arguing their cases. Because they are mostly practicing counselors, their writings are filled with case studies that illustrate the practical applications of their theory. Further, they attempt to collect data on their approach, and the results of these efforts are promising. The SF approach is appealing to many because of its brevity.

On the other hand, Miller (1994), in a very entertaining critique of SF counseling, pointed out that SF's claims of being different (quicker and better) are not supported by a review of the psychotherapy research. He pointed out that the average number of sessions for clients in any type of counseling is around five sessions. Further, you already know from reading Chapter 1 that very little evidence exists that demonstrates that any one theoretical approach produces better outcomes than others. The wise sage in Miller's article, Brief Throat, concludes, "The main impact of the solution-focused model—and any model of therapy, for that matter—is on the therapists that adhere to and practice the model's theoretical tenets and techniques and *not* on their clients!" (p. 29; italics in original). By saying this, Miller was pointing primarily to two issues: that the therapist's belief in her system boosts her effectiveness, and that across approaches, common factors produce client change. Claims that something special is happening in SF counseling, therefore, are simply ways to keep folks interested and invested in the approach.

Solution-Focused Therapy can be criticized on the charge that it is superficial; it lacks a theoretical structure through which client complaints can be understood. Piercy, Lipchik, and Kiser (2000) have suggested that SF theory should attend more to emotion and that its practitioners should be more flexible in their approaches to their clients. de Shazer and Dolan (2007) contend that an emphasis on emotions stems from traditional views of therapy in which such inner states are privileged over external or social and made into mystical, problematic things. They reply that SF Therapy

> does not view emotions as problems to be solved but rather views them as some of the many resources that clients have for constructing something "better." In other words, helping clients construct situations where they "feel better" and where they can remember that they feel better is one part of successfully constructing and "reinforcing" solutions by paying attention to the context in which emotions happen, SFBT keep them in

> their proper home, which is the client's everyday life, rather than making them an esoteric, mysterious phenomenon inside of the individual. (p. 149)

Those who choose other theoretical orientations that are concerned with underlying causal structures (e.g., psychoanalytic, existential) are likely to see SF Therapy as shallow. Proponents of the view that symptoms serve functions (i.e., almost all of the other counseling theories) would suggest that simple symptom relief would not last unless the function were replaced by some other means.

Qualities of the Theory

Precision and Testability. Because there is so little actual theory in SF Therapy, it would be difficult to operationalize the approach. Off the top of my head, a few possibilities suggest themselves, however. One might be able to track the exceptions identified by clients and relate them to outcomes. Certainly, solution statements could be counted.

Empirical Validity. Despite the efforts of SF Therapy's proponents to empirically validate their approach, most of the presentations of the theory rely on traditional (nonempirical) case study materials. Because relatively few empirical studies have been conducted on SF Therapy, the efficacy of this approach is not considered established.

Research Support

SFT has some empirical support, but because of the relative recency of the approach, the corpus of data is relatively small compared to other approaches. Therefore, I will bypass my usual division of this section into outcome and theory-testing research.

Macdonald (2007) compiled a list of studies relevant to SFT, finding 6 randomly controlled trials that supported the efficacy of the approach. Of particular interest was an unpublished meta-analysis of 22 studies that found significant, but small-effect sizes that favored SFT (Kim, 2006, cited by Macdonald, 2007). Although De Jong and Berg (2007) cite a number of reviews in support of the approach, several are not published in refereed journals and the quality of research is uneven.

Bertolino and O'Hanlon (2002) build a case for SF Therapy based on the common factors approach to psychotherapy outcome (see Chapter 1). They maintained that client factors are the single most powerful factors in therapy outcome and that these factors are reflective of client strengths, resources, and social support. Taking a collaborative, strength-based approach to counseling thus is based on empirical data. The therapist's assumption that change will happen bolsters "placebo" effects and builds client expectations.

Much to their credit, de Shazer and the therapists at the Brief Family Therapy Center (BFTC) have collected outcome data on some of their clients (De Jong & Berg, 2007; de Shazer, 1985, 1991). A study of 275 clients who presented for therapy at the BFTC in 1992 and 1993 found that 7 to 9 months after therapy, 45% of the 136 clients who could be contacted reported that their goals had been met in therapy; 32% reported some progress; 23% reported that they had made no progress in meeting their goals. Keep in mind that these are informal survey data, helpful, but subject to many potential pitfalls in terms of experimental design.

In a study of the first session formula task, de Shazer and Molnar (1984) had therapy team members (who were behind the one-way mirror) rate client responses to the first session task. They found that 57% of the 56 clients studied reported improvement between the first and second sessions. The average client in this study attended five sessions. In follow-up interviews conducted between 6 and 12 months after therapy, 23 of the 28 clients responding reported that their main complaint was "better." Interestingly, 25 of the 28 clients had mentioned a secondary complaint, and 11 of them (all from the successful cases) reported that improvement was seen in the secondary area as well, a finding that supports the "ripple effect." It is important to note, as did de Shazer, that these studies were exploratory in nature. No control or comparison groups were included, and random assignment of clients to therapists was not used, thus leaving the studies open to strong criticism on grounds of internal validity. Nonetheless, these therapists are commended on their attempts to validate their approach.

Studies conducted by researchers other than those at the Brief Family Therapy Center appear to have found similar results. Gingerich and Eisengart (2000) reviewed a selection of outcome studies of SF Therapy. Generally, they found that clients in SF counseling showed improvement relative to untreated clients (or standard treatment, such as in rehabilitation care). However, the methodological quality of the studies varies widely. To illustrate the state of the research on SF counseling, I will briefly review a few studies.

Wettersten, Lichtenberg, and Mallinckrodt (2005) explored the relationship between the working alliance and outcome in SF Therapy and Brief Interpersonal Therapy (BIT). Reasoning that the alliance should be more important in BIT than SF Therapy, Wettersten et al. compared a sample of 26 clients who received SF Therapy with an archival sample who had completed BIT. Interestingly, the results showed that the alliance scores of the two groups were similar when measured early in treatment and at termination. However, levels of symptom change, which overall, were similar in the two groups, were only correlated with the alliance for the BIT group. Wettersten et al. suggest that these findings indicate that although an alliance is necessary in SF Therapy, it is not a mechanism of change. This conclusion would be acceptable to proponents of SF Therapy, who would be pleased with the results for symptom change and also for client satisfaction, which was similar for the two groups.

Jakes and Rhodes (2003) reported on an interesting study of SF and cognitive-behavioral (CB) strategies with clients who had delusions. Five clients were intensively studied at baseline (no treatment) and as they were then treated with a SF and 2 CB interventions (schema-focused cognitive therapy and cognitive therapy focused on challenging the delusion) in that order. They observed that 2 of these clients (who were diagnosed with chronic psychosis as well as delusion for at least one year) responded positively (in terms of decreasing belief in their delusions) when they were treated with SF. All clients decreased their negative views about the self, and Jakes and Rhodes indicate that this effect was seen mostly in the SF phase of treatment. However, because this was a multiple case study design, we must be cautious in drawing causal inferences from its results.

Lee (1997) found that 65% of a sample of families participating in SF Therapy reported that their goals were either partly or completely met. This study was based on client self-report and did not include comparison groups. Clients engaged in an average of 5.5 sessions over 3.9 months. Beyebach, Morejon, Palenzuela, and Rodriguez-Arias (1996) reported that a study of 39 outpatients found an 80% goal achievement rate. De Jong and Hopwood

(1996) studied 275 clients who completed an average of 2.9 sessions. Forty-five percent of these clients reported achieving their goals, and 32% reported making "some progress."

Zimmerman, Prest, and Wetzel (1997) studied 36 couples treated in groups, comparing them to a control group of untreated couples. Couples receiving SF Therapy showed more improvement on the Dyadic Adjustment Scale compared to control couples. However, these results must be interpreted cautiously because of other methodological concerns with this research (e.g., the treatment group couples were distressed and seeking therapy; the control group couples did not identify themselves as dissatisfied with their relationships).

Individuals diagnosed as schizophrenic and their families were the participants in another study (Eakes, Walsh, Markowski, Cain, & Swanson, 1997). An interesting addition to the therapy in this study was that near the end of each session, the therapeutic team came from behind the one-way mirror and changed places with the family! This procedure then allowed the family to observe the team discussing the family's strengths and resources.

No standard outcome measures were used in Eakes and colleagues' study; instead, the researchers chose to examine perceptions of the family environment among control and treated participants. Clients who received Solution-Focused Therapy reported increases in family expressiveness and participation in social and recreational activities. In contrast, an untreated control group did not show these changes and instead increased in the degree to which they perceived disagreement among family members about the nature of the family environment.

Two studies have focused on the patterns of change among clients in SF Therapy. Interestingly, these studies were based on a research definition of SF Therapy developed by the European Brief Therapy Association (EBTA). The EBTA definition is as follows:

First session

The therapist . . .

1. . . . asks and follows up on the Miracle Question.
2. . . . asks and follows up on the Progress Scale Question (On a scale, where 10 stands for the day after the miracle and 0 stands for when the problems that brought you in were at their worst, where would you put yourself right now?).
3. . . . compliments the client(s) at the end of the session.

Second and following sessions

The therapist . . .

4. . . . asks "What is better?" at the beginning of the session and follows up on it.
5. . . . asks and follows up on the Progress Scale Question.
6. . . . compliments the client(s) at the end of the session.

Therapists will have to adjust to the exact wording and (where applicable) timing of these elements, as described in the following sections of this treatment protocol. Therapies where one or more of these elements are missing in one or more of the sessions can not be included in the sample.

Adapted from EBTA, 2007, European Brief Therapy Association Outcome Study: Research Definition Description of the Treatment.

Reuterlov, Lofgren, Nordstrom, Ternstrom, and Miller (2000) asked a sample of clients "what is better?" and examined their responses relative to scaling responses from the end of that same session. To ascertain whether clients had changed, they compared the scaling

responses obtained to those from the immediately preceding session. Some clients reply in the negative, and the approved SF procedure would be for the therapist to deconstruct this outcome and by the end of the session, the client should report improvement. Contrary to this supposition, Reuterlov et al. found that 87% of their clients stayed the same or declined by the end of the session (based on comparisons of ratings to those in a previous session). Thus, it seems that deconstructing client's negative reports might be a mistake—the therapist in this situation might need to "do something different."

De Vega and Beyebach (2004) set out to replicate Reuterlov et al.'s work with a sample of clients in Spain. Although De Vega and Beyebach found a similar pattern (about 63% of clients starting off negatively did not report improvement at the end of the session), the percentage of clients reporting improvement at the end of the session approximately tripled that found by Reuterlov et al. (37.5% vs. 13%). De Vega and Beyebach conclude that they are not quite as certain about the problematic nature of deconstruction—perhaps further research will reveal in what circumstances it is helpful and under which conditions it is not. However, it is worth noting that the samples in these two studies were different (Sweden vs. Spain) and the therapists differed, too.

Based on the foregoing review and other studies that report success rates from 64 to 75% (Macdonald, 1994, 1997; Reimer & Chatwin, 2006), it appears that SF Therapy is associated with desirable client change. Although these data may seem very convincing at first glance, it is important to remember that most of these studies were seriously flawed when evaluated according to standards generally accepted by psychotherapy outcome researchers (e.g., Chambless & Hollon, 1998; Lambert & Ogles, 2004). Thus, it is probably safe to conclude that the efficacy of Solution-Focused Therapy has not yet been established.

ISSUES OF INDIVIDUAL AND CULTURAL DIVERSITY

Because de Shazer and his colleagues maintain that they construct the view of the problem along with the client, they argue that they enter the client's world, avoiding any imposition of the counselor's perspective on the client (de Shazer, 1994). Great care is taken to take the client's presentation at face value and initially to work within the client's perceptual framework. Thus, these theorists would probably argue that their approach is, in fact, culturally bound, but to that of the client rather than to the culture of the theory or counselor. SF proponents have explored the use of this approach with a wide range of clients and presentations, including male cross-dressing (Dzelme & Jones, 2001), and religious/spiritual concerns (Guterman & Leite, 2006).

Corcoran (2000) evaluated the appropriateness of SF Therapy in working with African American and Mexican American clients. She contended that the SF emphasis on a brief approach, future orientation, and solutions rather than problems fit well for these clients. Further, Corcoran maintained that the SF approach "conveys respect for the unique world views of clients and how they solve problems" (2000, p. 11).

Berg and Miller (1992) and Chang and Yeh (1999) specifically evaluated the utility of SF Therapy for clients who are of Asian origin. Although these authors warned that to act on stereotypes of Asians or Asian Americans alone is risky, they maintained that certain aspects of SF counseling are very consistent with these clients' ideologies. They pointed out that because Asian Americans tend to seek counseling as a last resort, they are often in

crisis, which leads to a desire to focus on problems. Indeed, in general, individuals of Asian heritage are thought to be more comfortable problem solving than addressing emotional content (Berg & Miller, 1992). This problem focus helps the Asian client cope with the feelings of shame that are so powerful in the Asian culture. SF counseling would seem to be a good match for these clients because of its emphasis on rapid change as a result of an intense problem (solution) focus. Berg and Miller also noted that when therapists focus on exceptions, they are helping the Asian client "save face," an important cultural process. An even more specific application of SF Therapy with Asian clients was presented by Lee and Mjelde-Mossey (2006), who discussed using the approach to help East Asian elders and their families to address the problem of cultural dissonance.

Nonetheless, some of the same criticisms can be directed at this approach that are commonly directed at other theories of counseling. From a broad perspective, the notion of solutions may be culturally linked. For example, the search for exceptions is often behaviorally oriented and typically results in prescriptions for behavioral change. This individualistic focus may neglect the needs of individuals from more relationship-oriented cultures such as Latino/Latina or American Indian. However, Berg and Miller (1992) pointed out that SF counselors often help clients to explore exceptions by asking about how important others view the situation, thereby acknowledging the critical nature of these relationships. Individuals who have experienced oppression and discrimination (e.g., the physically challenged; African Americans; gays, lesbians, and bisexuals, or Latinos/Latinas) may find it difficult to focus narrowly on problems when so many social and cultural factors influence their daily lives.

SF Therapy is very focused and directive, which may clash with the values of clients from cultures that are less problem-oriented in their approaches to living. Women may find that the focus on problems and solutions neglects relationship themes that are important to them and de-emphasizes cultural factors that restrict their ability to directly problem solve. At the extreme, solution-focused counselors tend to follow almost a formula in dealing with clients, leading to very specific prescribed questions or tasks. For example, techniques such as scaling that reflect the pragmatic Western ideology may be foreign to clients from cultures other than traditional western cultures.

Dermer, Hemesath, and Russell (1998) pointed out that SF Therapy's emphasis on a collaborative relationship between client and counselor is consistent with feminist perspectives on counseling. However, they also asserted that SF theorists overlook the power of stereotypic roles and that the neutral stances of SF therapists may reinforce the (patriarchal) status quo. This neutral stance may also lead to the failure to assign responsibility for problems such as domestic violence even though the violence itself is condemned.

Rossiter (2000) noted that the SF therapist's eschewal of the past can potentially be problematic, particularly when working with clients from groups who have historically been oppressed or have experienced physical or sexual abuse. Encouraging the client to testify about injustices they have experienced is an important political event, according to Rossiter. Discouraging talk about the past is a serious mistake that potentially aligns the therapist with the historically privileged and powerful:

> it is chilling to contemplate therapy being used widely to conspire with silence by rendering history invisible and trivializing the symptoms (forms of telling) of injustice by managing them as "complaints." In such circumstances, the culture that therapy helps to create is invested in denial, repression, and abuse of power (p. 158; quotes in original).

THE CASE STUDY

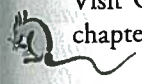
Understanding Kelly's presentation from the SF perspective is at first a little daunting. He speaks in problem language and labels himself as "an angry person" and "a perfectionist." It is somewhat difficult to find exceptions in his initial description although they are not difficult to imagine. He is clearly a customer (not a visitor or complainant) and is open to change, which makes it easier to use the SF approach. He identifies clear goals and has a number of strengths upon which the SF counselor, Mary, can draw. Because Kelly is a Caucasian male, potential issues of cultural bias are reduced. In summary, SF theory seems to fit well with Kelly's presentation.

Summary

SF counselors approach counseling with a model that focuses on client strengths and resources. It is a constructivist approach and is presented as a radical alternative to traditional models of counseling. Instead of spending a lot of time dissecting the client's (customer's) problem, attention is directed toward times when the complaint does not happen, or exceptions. Solutions are emphasized in this approach, and great care is taken to use language and techniques that emphasize exceptions rather than problem occurrences.

SF therapists do not use formal assessment, and they see the therapy relationship as collaborative. The SF counselor is an expert on change, but the client is the expert on how and what to change. The goals of therapy are set by the client, and the SF counselor's job is to redefine the problem so that it is solvable. The SF counselor helps the client to avoid doing more of the same and to increase the performance of exceptions to the problem.

Very little outcome research exists in support of SF therapy. What does appear is methodologically suspect. The constructivist approach of SF counseling may be beneficial for clients of diverse backgrounds, but the individualistic, solve-your-problem focus of SF counseling may neglect environmental factors that influence client presentations.



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