

**Solution Focused Therapy
Treatment Manual for Working with Individuals
Research Committee of the
Solution Focused Brief Therapy Association**

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The purpose of this Preliminary Treatment Manual is to offer an overview to the general structure of Solution-Focused Brief Therapy (SFBT). This manual will follow the standardized format and include each of the components recommended by Carroll and Nuro (1997). The following sections are included: (a) overview, description and rationale of SFBT; (b) goals and goal setting in SFBT; (c) how SFBT is contrasted with other treatments; (d) specific active ingredients and therapist behaviors in SFBT; (e) nature of the client-therapist relationship in SFBT; (f) format; (g) session format and content; (g) compatibility with adjunctive therapies; (h) target population; (i) meeting needs of special populations; (j) therapist characteristics and requirements; (j) therapist training; and (k) supervision.

OVERVIEW, DESCRIPTION, AND RATIONALE

Solution-Focused Brief Therapy group treatment is based on over twenty years of theoretical development, clinical practice, and empirical research (e.g., de Shazer et al., 1986; Berg & Miller, 1992; Berg, 1994; De Jong & Berg (2008); de Shazer, Dolan et al., 2006). Solution-Focused Brief Therapy is different in many ways from traditional approaches to treatment. It is a competency-based model, which minimizes emphasis on past failings and problems, and instead focuses on clients' strengths and previous successes. There is a focus on working from the client's understandings of her/his concern/situation and what the client might want different. The basic tenets that inform Solution-Focus Brief Therapy are as follows:

- It is based on solution-building rather than problem-solving.
- The therapeutic focus should be on the client's desired future rather than on past problems or current conflicts.
- Clients are encouraged to increase the frequency of current useful behaviors
- No problem happens all the time. There are exceptions – that is, times when the problem could have happened but didn't – that can be used by the client and therapist to co-construct solutions.

- Therapists help clients find alternatives to current undesired patterns of behavior, cognition, and interaction that are within the clients' repertoire or can be co-constructed by therapists and clients as such.
- Differing from skill-building and behavior therapy interventions, the model assumes that solution behaviors already exist for clients.
- It is asserted that small increments of change lead to large increments of change.
- Clients' solutions are not necessarily *directly* related to any identified problem by either the client or the therapist.
- The conversational skills required of the therapist to invite the client to build solutions are different from those needed to diagnose and treat client problems.

Solution-Focused Brief Therapy differs from traditional treatment in that traditional treatment focuses on exploring problematic feelings, cognitions, behaviors, and/or interaction, providing interpretations, confrontation, and client education (Corey, 1985). In contrast, SFBT helps clients develop a desired vision of the future wherein the problem is solved, and explore and amplify related client exceptions, strengths, and resources to co-construct a client-specific pathway to making the vision a reality. Thus each client finds his or her own way to a solution based on his or her emerging definitions of goals, strategies, strengths, and resources. Even in cases where the client comes to use outside resources to create solutions, it is the client who takes the lead in defining the nature of those resources and how they would be useful.

Solution-Focused Therapeutic Process

SFBT utilizes the same process regardless of the concern that the individual client brings to therapy. SFBT is an approach that focuses on *how* clients change, rather than one which focuses on diagnosing and treating problems. As such, it uses a language of *change*. The signature questions used in solution-focused interviews are intended to set up a therapeutic process wherein practitioners listen for and absorb clients' words and meanings (regarding what is important to clients, what they want, and related successes), then formulate and ask the next question by connecting to clients' key words and phrases. Therapists then continue to listen and absorb as clients again answer from their frames of reference, and once again formulate and ask the next question by similarly connecting to the client's responses. It is through this continuing process of listening, absorbing, connecting, and client responding that practitioners and clients together co-construct new and altered meanings that build toward solutions. Communication researchers McGee, Del Vento, and Bavelas (2005) describe this process as creating new common ground between practitioner and client in which questions that contain embedded assumptions of client competence and expertise set in motion a conversation in which clients participate in discovering and constructing themselves as persons of ability with positive qualities that are in the process of creating a more satisfying life. Examples of this therapeutic process are given below when the questions used in SFBT are presented.

General Ingredients of Solution Focused Brief Therapy

Most psychotherapy, SFBT included, consists of *conversations*. In SFBT there are three main general ingredients to these conversations.

First, there are the overall topics. SFBT conversations are centered on client concerns; who and what are important to the clients; a vision of a preferred future; clients' exceptions, strengths, and resources related to that vision; scaling of clients' motivational level and confidence in finding solutions; and ongoing scaling of clients' progress toward reaching the preferred future.

Second, as indicated in the previous section, SF conversations involve a therapeutic process of co-constructing altered or new meanings in clients. This process is set in motion largely by therapists asking SF questions about the topics of conversation identified in the previous paragraph and connecting to and building from the resulting meanings expressed by clients.

Third, therapists use a number of specific responding and questioning techniques that invite clients to co-construct a vision of a preferred future and draw on their past successes, strengths, and resources to make that vision a reality.

GOAL SETTING AND SUBSEQUENT THERAPY

The setting of specific, concrete, and realistic goals is an important component of SFBT. Goals¹ are formulated and amplified through SF conversation about what clients want different in the future. Consequently, in SFBT, clients set the goals. Once a beginning formulation is in place, therapy focuses on exceptions related to goals, regularly scaling how close clients are to their goals or a solution, and co-constructing useful next steps to reaching their preferred futures.

HOW SFBT IS CONTRASTED WITH OTHER TREATMENTS

SFBT is most similar to competency-based, resiliency-oriented models, such as some of the components of motivational enhancement interviewing (Miller & Rollnick, 2002; Miller, Zweben, DiClemente, & Rychtarik, 1994). There are also some similarities between SFBT and cognitive-behavioral therapy, although the latter model has the therapist assigning changes and tasks while SFBT therapists encourage clients to do more of their own previous exception behavior and/or test behaviors that are part of the client's description of their goal. SFBT also has some similarities to Narrative Therapy (e.g., Freedman & Combs, 1996) in that both take a non-pathology stance, are client-focused, and work to create new realities as part of the approach. SFBT is most dissimilar in terms of underlying philosophy and assumptions with any approach which requires "working through" or intensive focus on a problem to resolve it, or any approach which is primarily focused on the past rather than the present or future.

¹ Goals in SFBT are desired emotions, cognitions, behaviors, and interactions in different contexts (areas of the client's life).

SPECIFIC ACTIVE INGREDIENTS

Some of the major active ingredients in SFBT include (a) developing a cooperative therapeutic alliance with the client; (b) creating a solution versus problem focus; (c) the setting of measurable changeable goals; (d) focusing on the future through future-oriented questions and discussions; (e) scaling the ongoing attainment of the goals to get the client's evaluation of the progress made; and (f) focusing the conversation on exceptions to the client's problems, especially those exceptions related to what they want different, and encouraging them to do more of what they did to make the exceptions happen.

NATURE OF THE CLIENT-THERAPIST RELATIONSHIP

With SFBT, the therapist is seen as a collaborator and consultant, there to help clients achieve their goals. With SFBT, clients do more of the talking, and what they talk about is considered the cornerstone of the resolution of their complaints. Usually, SFBT therapists will use more indirect methods such as the use of extensive questioning about previous solutions and exceptions. In SFBT, the client is the expert, and the practitioner takes a stance of "not knowing" and of "leading from one step behind" through solution-focused questioning and responding .

FORMAT AND SESSION STRUCTURE

Much of the following is taken from de Shazer, Dolan et al. (2006).

Main Interventions

A positive, collegial, solution-focused stance. One of the most important aspects of SFBT is the general tenor and stance that is taken by the therapist. The overall attitude is positive, respectful, and hopeful. There is a general assumption that people are strongly resilient and continuously utilize this to make changes. Further, there is a strong belief that most people have the strength, wisdom, and experience to effect change. What other models view as "resistance" is generally seen as (a) people's natural protective mechanisms or realistic desire to be cautious and go slowly, or (b) a therapist error, i.e., an intervention that does not fit the clients' situation. All of these make for sessions that tend to feel collegial rather than hierarchical (although as noted earlier, SFBT therapists do "lead from behind"), and cooperative rather than adversarial.

Looking for previous solutions. SFBT therapists have learned that most people have previously solved many, many problems. This may have been at another time, another place, or in another situation. The problem may have also come back. The key is that the person had solved their problem, even if for a short time.

Looking for exceptions. Even when a client does not have a previous solution which can be repeated, most have recent examples of exceptions to their problem. An exception is thought of as a time when a problem could have occurred, but did not. The difference between a previous

solution and an exception is small but significant. A previous solution is something that the family has tried on their own that has worked, but for some reason they have not continued this successful solution, and probably forgot about it. An exception is something that happens instead of the problem, with or without the client's intention or maybe even understanding.

Questions vs. directives or interpretations. Questions are an important communication element of all models of therapy. Therapists use questions often with all approaches while taking history, when checking in at the beginning of a session, or finding out how a homework assignment went. SFBT therapists, however, make “questions” the primary communication and intervention tool. SFBT therapists tend to make no interpretations, and they very rarely directly challenge or confront a client

Present- and future-focused questions vs. past-oriented focus. The questions that are asked by SFBT therapists are almost always focused on the present or on the future, and the focus is almost exclusively on what the client wants to have happen in his life or on what of this that is already happening. This reflects the basic belief that problems are best solved by focusing on what is already working and how clients would like their lives to be, rather than focusing on the past and the origin of problems.

Compliments. Compliments are another essential part of SFBT. Validating what clients are already doing well and acknowledging how difficult their problems are encourages the client to change while giving the message that the therapist has been listening (i.e., understands) and cares (Berg & Dolan, 2001). Compliments in therapy sessions can help to punctuate what the client is doing that is working.

Gentle nudging to do more of what is working. Once SFBT therapists have created a positive frame via compliments and then discovered some previous solutions and exceptions to the problem, they gently nudge the client to do more of what has previously worked, or to try changes they have brought up which they would like to try – frequently called “an experiment.” It is rare for an SFBT therapist to make a suggestion or assignment that is not based on the client's previous solutions or exceptions. It is always best if change ideas and assignments emanate from the client at least indirectly during the conversation, rather than from the therapist because these behaviors are familiar to them.

Specific Interventions

Pre-session change. At the beginning or early in the first therapy session, SFBT therapists typically ask, “What changes have you noticed that have happened or started to happen since you called to make the appointment for this session?” This question has three possible answers. First, they may say that nothing has happened. In this case, the therapist simply goes on and begins the session by asking something like: “How can I be helpful to you today,” or “What would need to happen today to make this a really useful session?” or “How would your best friend notice if /that this session was helpful to you?” or “What needs to be different in your life after this session for you to be able to say that it was a good idea you came in and talked with me?”

The second possible answer is that things have started to change or get better. In this case, the therapist asks many questions about the changes that have started, requesting a lot of detail. This starts the process of “solution-talk,” emphasizing the client’s strengths and resiliencies from the beginning, and allows the therapist to ask, “So, if these changes were to continue in this direction, would this be what you would like?” thus offering the beginning of a concrete and positive goal.

The third possible answer is that things are about the same. The therapist might be able to ask something like, “Is this unusual, that things have not gotten worse?” or “How have you all managed to keep things from getting worse?” These questions may lead to information about previous solutions and exceptions, and may move them into a solution-talk mode.

Solution-focused goals. Like many models of psychotherapy, clear, concrete, and specific goals are an important component of SFBT. Whenever possible, the therapist tries to elicit smaller goals rather than larger ones. More important, clients are encouraged to frame their goals as the presence of a solution, rather than the absence of a problem. For example, it is better to have as a goal, “We want our son to talk nicer to us”—which would need to be described in greater detail – rather than, “We would like our child to not curse at us.” Also, if a goal is described in terms of its solution, it can be more easily scaled (see below).²

Miracle Question. Some clients have difficulty articulating any goal at all, much less a solution-focused goal. The miracle question is a way to ask for a client’s goal in a way that communicates respect for the immensity of the problem, and at the same time leads to the client’s coming up with smaller, more manageable goals. It is also a way for many clients to do a “virtual rehearsal” of their preferred future.

The precise language of the intervention may vary, but the basic wording is, “I am going to ask you a rather strange question [pause]. The strange question is this: [pause] After we talk, you will go back to your work (home, school) and you will do whatever you need to do the rest of today, such as taking care of the children, cooking dinner, watching TV, giving the children a bath, and so on. It will become time to go to bed. Everybody in your household is quiet, and you are sleeping in peace. In the middle of the night, a miracle happens and the problem that prompted you to talk to me today is solved! But because this happens while you are sleeping, you have no way of knowing that there was an overnight miracle that solved the problem. [pause] So, when you wake up tomorrow morning, what might be the small change that will make you say to yourself, ‘Wow, something must have happened—the problem is gone!’” (Berg & Dolan, 2001, p. 7.)

² Goals connect emotion, cognition, behavior, and interaction. So if the client says, “I don’t want to feel depressed” the therapist will start eliciting goals by asking how the client will notice when things become better and the client might answer, “I’d feel better. I’d be more calm and relaxed.” The therapist might then ask in what area of the client’s life that he will start noticing if he felt more calm and relaxed and the client might answer: when he is getting the children ready to go to school. The client will then be asked what the children will notice about him that says that he is more calm and relaxed, and how the children will behave differently when they are noticing this. The conversation might then move on to what differences this will make in other areas of the client’s life like the relationship with the partner or/and at work. The therapist will try to create descriptions of cognition, emotion, behavior, and interaction in several different contexts (parts of the client’s life) and people in these contexts. This is an important part of SFBT – connecting descriptions of both desired and undesired cognitions, emotions, behavior, and interactions with each other in contexts where they make sense.

Clients have a number of reactions to the question. They may seem puzzled. They may say they don't understand the question or that they "don't know." They may smile. Usually, however, given enough time to ponder it and with persistence on the part of the therapist, they start to come up with some things that would be different when their problem is solved. Here is an example of how a couple, both former drug dealers with several years of previous contact with therapists and social workers, who said they wanted "social services out of our lives" began to answer the miracle question. Insoo Kim Berg is the interviewer. Besides being a good example of how clients begin answering the miracle question, these excerpts illustrate SF co-construction between therapist and clients where altered or new meanings build as the therapist formulates next questions and responses based on the clients' previous answers and words, here about what will be different when the miracle happens:

Berg: (Finishing the miracle question with ...) So when you wake up tomorrow morning, what will be the first small clue to you... "whoa, something is different".

Dad: You mean everything's gone: the kids...everything?

Mom: No, no.

Berg: The problem is gone.

Dad: It never happened?

Mom: The problem happened but it's all better.

Berg: It's all handled now.

Mom: To tell you the truth, I probably don't know how...we're waiting. I mean, we're waiting on that day. We're waiting on that day when there is just nobody.

Berg: Nobody. No social service in your life.

Mom: Yeah.

Berg: How would you, when you sort of come out of sleep in the morning, and you look around and see, what will let you know... "wow, today is different, a different day today, something is different, something happened."

Dad: The gut feeling. The inside feeling. The monkey off the back so to speak.

Berg: O.K.

Dad: When I had a drug problem..., I guess it's a lot of the time the same feeling.

When I had a drug problem I always was searching, and just always something, I never felt good about it. You know.

Berg: (Connecting to client words and meanings, ignoring the "complaint statements" and choosing one part of the client's message that is connected with what they want to feel differently) So, after this miracle tonight, when the miracle happens, the problems are all solved, what would be different in your gut feeling?

Dad: Maybe I'd feel a little lighter, a little easier to move... not having to, ah, answer for my every movement.

Mom: Uh huh. Being able to make decisions as husband and wife. As parents of kids. Without having to wonder, "did we make the right decision or are we going to be judged on that decision?"

Berg: Oh.

Mom: I mean, this is what we feel is best, but when we have to answer *our* decision to somebody else ...

Dad: Yeah, I mean “try it this way,” or “try it that way,” well, I mean, it’s natural to learn a lot of those things on your own, I mean... I mean, you fail and you get back up and you try it another way.

Berg: So you would like to make the decision just the two of you, you were saying, “hmm, this makes sense, let’s do it this way” without worrying: “is someone going to look over our shoulder or not.”

Mom & Dad: Right.

Mom: And whether we agree or whether we disagree. To have somebody, have somebody taking sides, you know, what is his point, what is my point, and then trying to explain to us, well...

Dad: (Referring to social services) It was always having a mediator, I mean, ...

Mom: Yeah, there’s always somebody to mediate.

Berg: So the mediator will be gone. Will be out of your life.

Mom & Dad: Right.

Berg: (Connecting again to client words/meanings; accepting and building) O.K. All right. All right. So suppose, suppose all these mediators are out of your life, including me. What would be different between the two of you? (Silence)

Dad: (Sighs)

Mom: Everything. Like I said, being able to look at each other as husband and wife and know that if we have, if we agree on something, that that is *our* decision, and that’s the way it’s going to be. If we disagree on something, it’s a decision that, I mean, that’s something we have to work out between us, and we don’t have to worry what that third person’s opinion is going to be, and I don’t have to have a third person saying, “Yes, well, I agree, the way Keith decided it was right.” Which makes me feel even *more* belittled.

Berg: All right. So, you two will make decisions regarding your family. What to do about the kids, what to do about the money, going to do whatever, right?

Mom: Right.

Berg: Suppose you were able to do that without second guessing. What would be different between the two of you...that will let you know, “Wow! This is different! We are making our own decisions.”

Mom: A lot of tension gone I think. ...

And so forth.

What clients are able to co-construct with the therapist in answer to the miracle question can usually be taken as the goals of therapy. With a detailed description of how they would like their lives to be, clients often can turn more easily to building enhanced meanings about exceptions and past solution behaviors that can be useful in realizing their preferred futures.

In therapy with couples or families or work groups, the miracle question can be asked to individuals or the group as a whole. If asked to individual members, each one would give his or her response to the miracle question, and others might react to it. If the question is asked to the family, work group, or couple as a whole, members may “work on” their miracle together. The SFBT therapist, in trying to maintain a collaborative stance among family members, punctuates similar goals and supportive statements among family members.

Scaling questions. Whether the client gives specific goals directly or via the miracle question, an important next intervention in SFBT is to have the client evaluate his own progress. The therapist asks the Miracle Question's Scale: From 0-10 or from 1-10, where 0 means when the initial appointment was arranged and 10 means the day after the miracle, where are things now? For example, with a couple where better communication is their goal:

Therapist: What I want to do now is scale the problem and the goal. Let's say a 1 is as bad as the problem ever could be, you never talk, only fight, or avoid all the time. And let's say a 10 is where you talk all the time, with perfect communication, never have a fight ever.

Husband: That is pretty unrealistic

T: That would be the ideal. So where would you two say it was for you at its worst? Maybe right before you came in to see me.

Wife: It was pretty bad... I don't know... I'd say a 2 or a 3.

H: Yeah, I'd say a 2.

T: Ok (writing)... a 2-3 for you, and a 2 for you. Now, tell me what you would be satisfied with when therapy is over and successful?

W: I'd be happy with an 8.

H: Well, of course I'd like a 10, but that is unrealistic. Yeah, I'd agree, an 8 would be good.

T: What would you say it is right now?

W: I would say it is a little better, because he is coming here with me, and I see that he is trying... I'd say maybe a 4?

H: Well that's nice to hear. I wouldn't have thought she'd put it that high. I would say it is a 5.

T: Ok, a 4 for you, a 5 for you. And you both want it to be an 8 for therapy to be successful, right?

There are three major components of this intervention. First, it is an assessment device. That is, when used each session, the therapist and the clients have an ongoing measurement of the client's progress. Second, it makes it clear that the client's evaluation is more important than the therapist's. Third, it is a powerful intervention in and of itself, because it focuses the dialogue on previous solutions and exceptions, and punctuates new changes as they occur. Like the changes made before the first session, here are three things which can happen between each session: (a) things can get better, (b) things can stay the same, (c) things can get worse.

If the scale goes up, the therapist gets long descriptions and details as to what is different and better and how they were able to make the changes. The therapist may compliment the client during the session for progress made or/and he may comment on the changes in summary of the session. This supports and solidifies the changes, and leads to the obvious nudge to "do more of the same." If things "stay the same," again, the clients can be complimented on maintaining their changes, or for not letting things get worse. "How did you keep it from going down?" the therapist might ask. It is interesting how often that will lead to a description of changes that they have made, in which case again the therapist can compliment and support and encourage more of that change.

T: Mary, last week you were a 4 on the scale of good communications. I am wondering where you are this week?

W: [pause] I'd say a 5.

T: A 5! Wow! Really, in just one week.

W: Yes, I think we communicated better this week.

T: How did you communicate better this week?

W: Well, I think it was Rich. He seemed to try to listen to me more this week.

T: That's great. Can you give me an example of when he listened to you more?

W: Well, yes, yesterday for example. He usually calls me once a day at work, and...

T: Sorry to interrupt, but did you say he calls you once a day? At work?

W: Yes

T: I'm just a little surprised, because not all husbands call their wives every day.

W: He has always done that.

T: Is that something you like? That you wouldn't want him to change?

W: Yes, for sure.

T: Sorry, go on, you were telling me about yesterday when he called.

W: Well, usually it is kind of a quick call. But I told him about some problems I was having, and he listened for a long time, seemed to care, gave me some good ideas. That was nice.

T: So that was an example of how you would like it to be, where you can talk about something, a problem, and he listens and gives good ideas? Support?

W: Yes.

T: Rich, did you know that Mary liked your calling her and listening to her? That that made you two move up the scale, to her?

H: Yeah, I guess so. I have really been trying this week.

T: That's great. What else have you done to try to make the communication better this week?

This example shows how going over the scale with the couple served as a vehicle for finding the client's progress. The therapist gathered more and more information about the small changes that the clients made on their own using the differences on the scale to generate questions. This naturally led to the therapist's suggesting that the couple continue to do the things that are working, in this case for the husband to continue his calling her, and his continuing to engage in the active listening that she found so helpful.

Constructing solutions and exceptions. The SFBT therapist spends most of the session listening attentively for talk about previous solutions, exceptions, and goals. When these come out, the therapist punctuates them with enthusiasm and support. The therapist then works to keep the solution-talk in the forefront. This, of course, requires a whole range of different skills from those used in traditional problem-focused therapies. Whereas the problem-focused therapist is concerned about missing signs of what has caused or is maintaining a problem, the SFBT therapist is concerned about missing signs of progress and solutions.

Mother: She always just ignores me, acts like I'm not there, comes home from school, just runs into her room. Who knows what she is doing in there.

Daughter: You say we fight all the time, so I just go in my room so we don't fight.

M: See? She admits she just tries to avoid me. I don't know why she can't just come home and talk to me a little about school or something, like she used to.

T: Wait a second, when did she "used to"? Anita, when did you use to come home and tell your mom about school?

D: I did that a lot, last semester I did.

T: Can you give me an example of the last time you did that?
M: I can tell you, it was last week actually. She was all excited about her science project getting chosen.
T: Tell me more, what day was that...?
M: I think last Wednesday.
T: And she came home...
M: She came home all excited.
T: What were you doing?
M: I think the usual, I was getting dinner ready. And she came in all excited, and I asked her what was up, and she told me her science project was chosen for the display at school.
T: Wow, that is quite an honor.
M: It is.
T: So then what happened?
M: Well, we talked about it, she told me all about it.
T: Anita, do you remember this?
D: Sure, it was only last week. I was pretty happy.
T: And would you say that this was a nice talk, a nice talk between you two?
D: Sure. That's what I mean; I don't always go in my room.
T: Was there anything different about that time, last week, that made it easier to talk to each other?
M: Well, she was excited.
D: My mom listened, wasn't doing anything else.
T: Wow, this is a great example. Thank you. Let me ask this: if it were like that more often, where Anita talked to you about things that were interesting and important to her, and where Mom, you listened to her completely without doing other things, is that what you two mean by better communication?
D: Yeah, exactly.
M: Yes

In this example, the therapist did a number of things. First, she listened carefully for an exception to the problem, a time when the problem could have happened but did not. Second, she punctuated that exception by repeating it, emphasizing it, getting more details about it, and congratulating them on it. Third, she connected the exception to their goal (or miracle) by asking the question, "If this exception were to occur more often, would your goal be reached?"

Coping questions. If a client reports that the problem is not better, the therapist may sometimes ask coping questions such as, "How have you managed to prevent it from getting worse?" or "This sounds hard – How are you managing to cope with this to the degree that you are?"

Taking a break and reconvening. Many models of family therapy have encouraged therapists to take a break toward the end of the session. Usually this involves a conversation between the therapist and a team of colleagues or a supervision team who have been watching the session and who give feedback and suggestions to the therapist. In SFBT, therapists are also encouraged to take a break near the session end. If there is a team, they give the therapist feedback, a list of compliments for the family, and some suggestions for interventions based on

the clients strengths, previous solutions, or exceptions. If there is a not a team available, the therapist will still take a break to collect his or her thoughts, and then come up with compliments and ideas for possible experiments. When the therapist returns to the session, he or she can offer the family compliments.

T: I just wanted to tell you, the team was really impressed with you two this week. They wanted me to tell you that, Mom, they thought you really seem to care a lot about your daughter. It is really hard to be a mom, and you seem so focused and clear about how much you love her and how you want to help her. They were impressed that you came to session today, in spite of work and having a sick child at home. Anita, the team also wanted to compliment you on your commitment to making the family better. They wanted me to tell you how bright and articulate they think you are, and what a good “scientist” you are! Yes, that you seem to be really aware of what small, little things that happen in your family that might make a difference... That is what scientists do, they observe things that seem to change things, no matter how small. Anyway, they were impressed with you two a lot!

D: [Seeming pleased.] Wow, thanks!

Experiments and homework assignments. While many models of psychotherapy use intersession homework assignments to solidify changes begun during therapy, most of the time the homework is assigned by the therapist. In SFBT therapists frequently end the session by suggesting a possible experiment for the client to try between sessions if they so choose. These experiments are based on something the client is already doing (exceptions), thinking, feeling, etc. that is heading them in the direction of their goal. Alternately, homework is sometimes designed by the client. Both follow the basic philosophy that what emanates from the client is better than if it were to come from the therapist. This is true for a number of reasons. First, what is usually suggested by the client, directly or indirectly, is familiar. One of the main reasons homework is not accomplished in other models is that it is foreign to the family, thus takes more thinking and work to accomplish (usually thought of as “resistance”). Second, the clients usually assign themselves either more of what has worked already for them (a previous solution) or something they really want to do. In both cases, the homework is more tied to their own goals and solutions. Third, when a client makes his or her own homework assignment, it reduces the natural tendency for clients to “resist” outside intervention, no matter how good the intention. While SFBT does not focus on resistance (in fact, sees this phenomenon as a natural, protective process that people use to move slowly and cautiously into change rather than as evidence of psychopathology), certainly, when clients initiate their own homework, there is a greater likelihood of success.

T: Before we end today, I would like for you two to think about a homework assignment. If you were to give yourselves a homework assignment this week, what would it be?

D: Maybe that we talk more?

T: Can you tell me more?

D: Well, that I try to talk to her more when I come home from school. And that she stops what she is doing and listen.

T: I like that. You know why? Because it is what you two were starting to do last week. Mom, what do you think? Is that a good homework assignment?

M: Yeah, that’s good.

T: So let's make this clear. Anita will try to talk to you more when she comes home from school. And you will put down what you are doing, if you can, and listen and talk to her about what she is talking to you about. Anything else? Anything you want to add?

M: No, that's good. I just need to stop what I was doing, I think that is important to listen to her.

T: Well that sure seemed to work for you two last week. OK, so that's the assignment. We'll see how it went next time.

A couple of points should be emphasized here: First, the mother and daughter were asked to make their own assignment rather than have one imposed on them by the therapist. Second, what they assigned themselves flowed naturally from their previous solution and exceptions from the week before. This is very common and is encouraged by SFBT therapists. However, even if the client suggested an assignment which was not based on solutions and exceptions to the problem, the therapist would most likely support it. What is preeminent is that the assignments come from the client.

In cases where the client has not been able to form a clear goal the therapist may propose that the client thinks about how he wants things to be by, for instance, using the FFST (formula first session task; de Shazer, 1992, 1995).

Ideas around what the therapist thinks might be useful for the client to observe may (and will often) be given with the end-of-session message. These will have something to do with what the client described in the miracle.

So, what is better, even a little bit, since last time we meet? At the start of each session after the first, the therapist will usually ask about progress, about what has been better during the interval. Many clients will report that there have been some noticeable improvements. The therapist will help the client describe these changes in as much detail as possible. Of course some clients will report that things have remained the same or have gotten worse. This will lead the therapist to explore how the clients have maintained things without things getting worse; or, if worse, what did the client do to prevent things from getting much worse. Whatever the client has done to prevent things from worsening is then the focus and a source for compliments and perhaps for an experiment since whatever they did they should continue doing. During the session, usually after there has been a lot of talk about what is better, the therapist will ask the client about how they would now rate themselves on the progress (toward solution) scale. Of course when the rating is higher than the previous session's, the therapist will compliment this progress and help the client figure out how they will maintain the improvement.

At some point during the session – possibly at the beginning, perhaps later in the session – the therapist will check, frequently indirectly, on how the assignment went. If the client did the assignment, and it “worked” – that is, it helped them move toward their goals – the therapist will compliment the client. If they did not do their assignment, the therapist usually drops it, or asks what the client did instead that was better.

One difference between SFBT and other homework-driven models, such as cognitive-behavioral therapy, is that the homework itself is not required for change per se, so not completing an assignment is not addressed. It is assumed if the client does not complete an

assignment that (a) something realistic got in the way of its completion, such as work or illness; (b) the client did not find the assignment useful; or (c) it was basically not relevant during the interval between sessions. In any case, there is no fault assigned. If the client did the assignment but things did not improve or got worse, the therapist handles this in the same way he or she would when problems stay the same or got worse in general.

COMPATIBILITY WITH ADJUNCTIVE THERAPIES

SFBT can easily be used as an addendum to other therapies. One of the original and primary tenets of SFBT – “If something is working, do more of it” – suggests that therapists should encourage their clients to continue with other therapies and approaches that are helpful. For example, clients are encouraged to (a) continue to take prescribed medication, (b) stay in self-help groups if it is helping them to achieve their goals, or (c) begin or continue family therapy. Finally, it is a misconception that SFBT is philosophically opposed to traditional substance abuse treatments. Just the opposite is true. If a client is in traditional treatment or has been in the past and it has helped, he or she is encouraged to continue doing what is working. As such, SFBT could be used in addition to or as a component of a comprehensive treatment program.

TARGET POPULATIONS

SFBT has been found clinically to be helpful in treatment programs in the U.S. for adolescent and adult outpatients (Pichot & Dolan, 2003), and as an adjunct to more intensive inpatient treatment in Europe. SFBT is being used to treat the entire range of clinical disorders, and is also being used in educational and business settings. Meta-analysis and systematic reviews of experimental and quasi-experimental studies indicate that SFBT is a promising intervention for youth with externalizing behavior problems and those with school and academic problems, showing medium to large effect sizes (Kim, in press; Kim & Franklin, 1997).

MEETING THE NEEDS OF SPECIAL POPULATIONS

While SFBT may be useful as the primary treatment mode for many individuals in outpatient therapy, those with severe psychiatric, medical problems, or unstable living situations will most likely need additional medical, psychological, and social services. In those situations, SFBT may be part of a more comprehensive treatment program.

THERAPIST CHARACTERISTICS AND REQUIREMENTS

SFBT therapists should possess the requisite training and certification in mental health discipline, and specialized training in SFBT. The ideal SFBT therapist would possess (a) a minimum of a master’s degree in a counseling discipline such as counseling, social work, marriage and family therapy, psychology, or psychiatry; (b) formal training and supervision in

solution-focused brief therapy, either via a university class or a series of workshops and training. Therapists who seem to embrace and excel as solution focused therapists have these characteristics: (a) are warm and friendly; (b) are naturally positive and supportive (often are told they “see the good in people”); (c) are open minded and flexible to new ideas; (d) are excellent listeners, especially the ability to listen for clients’ previous solutions embedded in “problem-talk”; and (e) are tenacious and patient.

THERAPIST TRAINING

Therapists who meet the above requirements should receive formal training and supervision in SFBT. A brief outline of such a training program would include:

1. History and philosophy of SFBT
2. Basic tenets of SFBT
3. Session format and structure of SFBT
4. Video examples of “Masters” of SFBT
5. Format of SFBT
6. Video examples of SFBT
7. Role playing
8. Practice with video feedback
9. Training with video feedback

Therapists can be considered trained when they achieve an 85% adherence and competency rating using standardized adherence and competency rating scales. There should also be subjective evaluations by the trainers as to therapists’ overall ability to function reliably and capably as solution focused therapists.

SUPERVISION

SFBT therapists should be supervised live whenever possible. One of the most common problems is the therapist slipping back into “problem talk.” It is far better for the therapist-in-training to receive concurrent feedback, via telephone call-in for example, so that this can be corrected immediately. “Solution-talk” is far more likely to become natural and accommodated by therapists when given immediate feedback, especially early in training. The other advantage to live supervision, of course, is that there is a second set of “clinical eyes,” which also will benefit the clients, especially more difficult cases. When live supervision is not possible, then videotape supervision is the best alternative, since the movement and body language of the group is relevant to the feedback that the supervisor will want to give the therapist. Adherence and competency scales should be used as an adjunct to supervision, to focus the supervision on balancing both the quantity of interventions (adherence) and the quality (competency) and allow for more immediate remediation.

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