Building Alternative Futures: The Solution-Focused Approach

Brian Cade, B.A. C.S.W.

> *We believe that it is useful to think about solution-focused therapy as a rumor. It is a set of stories that circulate within and through therapist communities. The stories are versions of the solution-focused therapy rumor. Whilst the names of the major characters usually remain stable, the plots and contexts that organize the action may vary from one story telling episode to the next.* (Miller & de Shazer, 1998, p. 364)

The Central Philosophy of Brief and Solution-Focused Therapy

1. If it works, do more of it
2. If it doesn't work, do something different
3. If it ain't broke, don't fix it.

This chapter will consider the approaches and techniques that have become subsumed under the general heading of "solution-focused" (Berg, 1994; Berg & Miller, 1992; de Shazer, 1985; de Shazer, 1988; de Shazer, 1991; de Shazer, 1994; de Shazer, et al., 1986; De Jong & Berg, 1998; Furman & Ahola, 1992; Miller, et al., 1996; Walter & Peller, 1992). I clearly take responsibility for the particular twists I will give to the "solution-focused rumor".

Some of the Historical Background

The origins of the approaches lie primarily in the brilliant and idiosyncratic work of Milton H. Erickson (Erickson & Rossi, 1979; Erickson, et al., 1976; Haley, 1967; Haley, 1973; O'Hanlon, 1987; Rosen, 1982; Rossi, 1980) and in the work of the Brief Therapy Center, Palo Alto (Fisch, et al., 1982; Ray & de Shazer, 1999; Watzlawick, 1978; Watzlawick & Weakland, 1977; Watzlawick, et al., 1974; Weakland, et al., 1974; Weakland & Ray, 1995).

Milton Erickson worked from the assumption that people already have, from within their own personal experiences and histories, the resources and areas of competence they need from which to draw in order to to surmount their difficulties. He did not operate from a clearly articulated theory of personality or of dysfunction but seemed to work from an implicit theory of therapy, of what helped people to change. Neither did he operate from a deficit model. He believed that people made the best choices they see as being available for themselves at any given moment, and that the therapist should listen carefully to and respect all communications from the client. He saw it as the job of the therapist to meet the client in his or her own world rather than to try to work from or to impose elements of the therapist's world.

Equally as important as Erickson's legendary genius for constructing brilliant and unpredictable interventions was the profound level of respect he showed for his patients, for their beliefs, for their integrity and for their capacity to change, however chronic or acute their problems. His influence on the development of the brief approaches was profound. In an interview, video-taped just a few months before his death, John Weakland, a founding member of the Brief Therapy Center, Palo Alto, was asked what he had learned from Erickson. He replied,

> "A great deal ..... I learned something about paying close attention to clients. I learned something about change being always possible even in what appear to be desperate and fixed and concrete situations; and I learned that it's the business of a therapist essentially to take charge and influence people to make changes in useful directions ..... It was remarkable to us to see the things that Erickson could get people to do that were different from what they were accustomed to doing." (Chaney, 1995)

The Brief Therapy Center was set up in 1966 within the Mental Research Institute, Palo Alto, California, primarily at the initiative of Dick Fisch, and included John Weakland and Paul

Watzlawick. This group had a profound effect on the subsequent interest in and rapid development of the brief approaches throughout the world. John Weakland, who with Jay Haley and Don Jackson had earlier been part of the influentual Gregory Bateson project which studied the paradoxes of abstraction in communication and evolved the interactional view (Bateson, et al., 1956; Berger, 1978; Sluzki & Ransom, 1976; Watzlawick & Weakland, 1977), described the origins of the brief therapy project as follows,

> "To my mind we only had two or three basic ideas, which led to everything else. One, of course, was that we would work as a group. One person would be the therapist; the others would observe, and then everything would be recorded and discussed.
>
> "But the two main principles that I think were responsible for the directions we took within that framework were, one, that we would focus on the client's main presenting complaint and STICK TO IT; not try to look around it or behind it or beneath it but stick to what's the main presenting complaint. And the other thing was that, by that time, we realised that it was not so easy to get people to change. So ..... we would try anything that we could think of that was legal or ethical regardless of whether it was conventional, or a long, long way from conventional thinking. I think things just grew out of that." (Chaney, 1995)

It is difficult nowadays, with the use of teams, one-way mirrors and video-recorders being so commonplace, to appreciate how revolutionary, at that time, this procedural approach was. Particularly revolutionary was the decision to remain tightly focused on what the client defined as the problem, making no assumptions about the existence of "deeper", underlying issues or of the function of symptoms. The group proceeded to elaborate an approach to therapy that evolved out of the direct observation of the process of trying to help people change, and from the detailed analysis of tape-recordings of therapy sessions. No unprovable assumptions were evoked or used. They took care not to stray too far from pragmatics, from what could be unequivocally observed and clearly described. This stood in considerable contrast to other models prevalent at the time where the therapeutic approach arose out of the dictates of the tenets of sometimes quite complex theories. One of this group's most influential ideas was the notion that problems develop from and are maintained by the way that, under certain circumstances, particular, and often quite normal, life difficulties become perceived and subsequently tackled. Guided by reason, logic, tradition or "common sense", various attempted solutions are applied (which can include a denial of the difficulty) which either have little or no effect or, alternatively, can exacerbate the situation. A problem then becomes entrenched as **more of the same** solutions, or classes of solutions, become followed by **more of the same** problem, attracting **more of the same** attempted solutions, and so on … A vicious circle develops and the continued application of "wrong" or inappropriate solutions that lock the difficulty into a self-reinforcing, self-maintaining pattern can be seen as becoming the problem. Therapy is focused on changing the "attempted solutions", on stopping or even reversing the usual approach, however logical or correct it appears to be. The assumption is that, once the feedback loops maintaining the problem are changed, a greater range of responses become available.

Among the increasing number of professionals who began to have contact with this project in the late sixties and early seventies were Steve de Shazer and Insoo Kim Berg, who were to become so influential in the development of the solution-focused approaches. De Shazer has recently talked of the earlier influence on him of the work of Milton Erickson and of Jay Haley's ground-breaking book, *Strategies of Psychotherapy* (Haley, 1963),

> Until I read this book, as far as I can remember, I had never even heard the term "psychotherapy." Certainly this was the first book on the topic that I read. I enjoyed it perhaps more than any other "professional book" I'd read in philosophy, art history, architecture, or sociology. So, I went to the library and looked at its neighbors. I was shocked. I was unable to finish any of the others I tried to read: After Strategies - which made so much sense to me - everything else was (poorly written) nonsense until I found Advanced Techniques of Hypnosis and Therapy which is a selection of Milton H. Erickson's papers. It is not going too far to say that these two books changed my life and shaped my future. Unlike so many other "professional books," the books by Erickson and Haley were well written. They were clear. (I then read everything else they had written and I followed their references

> to other authors and other articles and books) Among other things these books implicitly and indirectly (at times) suggested many of the themes that would form my career, including the idea of “brief therapy”. (de Shazer, 1999)

The Brief Family Therapy Center was set up in Milwaukee in 1978. As de Shazer comments,

> ... Insoo and I and a group of our colleagues - who had been working together (secretly) for many years - decided to set up an independent “MRI of the Midwest” where we could both study therapeutic effectiveness, train therapists to do things as efficiently as possible, and, of course, practice therapy. (de Shazer, 1999)

In addition to Steve de Shazer and Insoo Kim Berg, the original Milwaukee group included James Derks, Marvin Weiner, Elam Nunnally, Eve Lipchick, Alex Molnar and Marilyn La Court. Over time, the membership of the team was continually to evolve. Among the later members who were also to make a significant contribution were Wallace Gingerich, Michele Weiner-Davis, John Walter, Kate Kowalski, Ron Kral, Gale Miller, Scott Miller and Larry Hopwood. In those early days, the group was largely using a problem-focused model very similar to and influenced by that of the Palo Alto Brief Therapy Center. However, in the early 1980s, it became increasingly interested in what clients were already doing on their own to solve their problems and in clients’ own ideas about what they wanted changed, about how things could be different and what it would take to bring about these changes. This focus on a description of solutions rather than on a clarification of problems and failed solutions led quickly to the realisation that it was not necessary to know much or sometimes even anything about the problem or its origins, assuming they could ever reliably be established, to get the process of change started. They began to see the client as the expert in their own lives.

Keys to Solution

In 1984, de Shazer and Molnar outlined a first-session-task that was routinely being given to clients regardless of the nature of the presenting problem.

> “Between now and the next time we meet, we (I) want you to observe, so that you can tell us (me) next time, what happens in your (life, marriage, family, or relationship) that you want to continue to have happen” (de Shazer & Molnar, 1984, p. 298).

They discovered that, in a significant number of cases, concrete changes occurred between the giving of this task and the following session.

> With surprising frequency (50 of 56 in a follow-up survey), most clients notice things they want to have continue and many (45 of the 50) describe at least one of these as “new or different.” Thus, things are on the way to solution; concrete, observable changes have happened. (de Shazer et al., 1986, p. 217)

Moshe Talmon described how, working in a medical health centre, he would give a suggestion similar to de Shazer's first session task to patients during the initial phone contact while a first appointment was being set up (Talmon, 1990, p. 19) . Weiner-Davis, et al. found that, in a significant proportion of cases, significant changes frequently seemed to occur prior to the first appointment even where no such suggestion had been offered. They would ask the following question,

> “Many times people notice in between the time they make the appointment for therapy and the first session that things already seem different. What have you noticed about your situation?” (Weiner-Davies, et al., 1987, p. 306)

In *Keys to Solution in Brief Therapy* (de Shazer, 1985), de Shazer described the development of further “formula interventions” through which, it was argued, the process of building solutions could be started. He invoked the analogy of a skeleton key in that, with just one skeleton key, a whole range of different locks can be opened without the need to find the exact key that will fit the exact shape of each and every lock.

Molnar and de Shazer elaborated a list of these formula interventions,

> 1. Client is asked to do more of the behaviors which are satisfactory and different from the problem behavior
>
> 2. Client is asked to: "pay attention to what you do when you overcome the temptation or urge to ... " (perform the symptom or some behavior associated with the symptom).
>
> 3. Client is given a prediction assignment such as whether in the time between sessions there will be more instances of behavior that are an exception to the problem behavior.
>
> 4. Client is told "Between now and the next time I (we) would like you to do something different and then tell me (us) what happened."
>
> 5. Client is asked to do a structured task (such as keeping a log of certain incidents) which is related to those times when the problem behavior ceases or is not present.
>
> 6. Client is told: "The situation is very (complicated, volatile, etc.). Between now and the next time, attempt to identify why the situation is not worse."
>
> (Molnar & de Shazer, 1987, p. 355)

The common theme with each of these interventions is that they are concerned with and focus the client and the process of therapy on what has worked, is working, or is beginning to work, rather than with exploring or categorizing pathology. They operate from an assumption that change is inevitable and that people are already bringing it about or have all that is necessary to do so. The group continued to seek clearer and more precise descriptions of the essence of what it takes to be therapeutic. What works? On the way they dropped those assumptions, ways of thinking or of intervening that they discovered to be unnecessary or unhelpful. Many of these latter included assumptions and approaches that are often seen as of central importance in many other approaches (e.g. clear problem definition, hypothesizing and diagnosis). In 1988, with his next book, *Clues: Investigating Solutions in Brief Therapy*, de Shazer summarized the basic principles behind and techniques used in the solution-focused approach that have since then been its essential features (de Shazer, 1988). More recently, these characteristic features have been summarised as follows,

> (1) At some point in the first interview, the therapist will ask the 'Miracle Question'.
>
> (2) At least once during the first interview and at subsequent ones, the client will be asked to rate something on a scale of '0 - 10' or '1 - 10'.
>
> (3) At some point during the interview, the therapist will take a break.
>
> (4) After this intermission, the therapist will give the client some compliments which will sometimes (frequently) be followed by a suggestion or homework task (frequently called an experiment). (de Shazer & Berg, 1997, p. 123)

Language and Figure/Ground

> *"As a thing is viewed, so it appears"* The Tibetan Book of the Great Liberation (Evans-Wentz, 1969).

Solution-focused therapy has developed within the tradition of the constructivist/constructionist thinking of the interactional view. In seeking to describe, understand and explain human behaviour, there is no one reality "out there" available for objective analysis. There are as many "realities" as there are observers or groups of observers. Reality, in terms of the way it is experienced and reacted to, is constructed out of the way that each individual perceives, divides up, makes sense of, allocates meaning to **and talks about** his or her world, which is in turn embedded in and powerfully affected by the negotiations about reality that continually evolve in the interactions between people from the

level of dyad, family, kinship and friendship networks, through larger and larger communities of (and means of) connection, including local, national and international social, political and knowledge systems, up to, nowadays, the instant global reach of the media and the worldwide community(ies) of the internet.

Language is clearly the primary medium through which such realities are negotiated and, in every area of discourse and at all levels of discourse, ways of using language develop that both reflect and transmit the needs and the essence of that particular area of discourse. Particular clusters of words and phrases and ways of using them, tend to be favoured and take on meanings, or shades of meaning, relevant to the context. The philosopher Ludwig Wittgenstein evoked the term "language game" to highlight the way that the meaning of words stands not in a fixed relation between each word and some aspect of reality that it denotes, but in a local convention of usage that varies from context to context and is dependent on the spirit within which they are being used. Different language games would be used in, for example, an attempt at seduction, negotiating a loan with a bank manager, union-employer bargaining, gossiping with a neighbour, discussing a scientific theory, and engaging in an act of communal worship. Each would clearly be conducted in a different manner and the words used would be chosen, and would take on conventions of meaning and association, relevant to the activity and the traditions and customary expectations of those involved. We cannot move outside of language so, in the same way that a fish can be seen as being unaware that it is in water, we can remain unaware of the particular language game we are immersed in because it is so familiar to us. As an example of how a word can have a meaning within but be relatively meaningless outside of a "language game",

> Take the word "good". What is common between a good joke, a good player, a good man, feeling good, good will, good breeding, good looking, and a good for nothing? There is no one common property which the word **good** refers to. We cannot analyse the word so that we reach some essence or element from which the concept is built up ... But there are resemblances between the various meanings of the term ... The circumstances in which the words are used give the clue. Specificity does not belong to the **experience** but to the **language game** which enables us to talk about or express our desires, intentions, meanings, etc.. Meaning depends on articulation rather than representation. What is specific is always a function of the language game and can only be articulated within it. (Heaton & Groves, 1994, pp. 127-9)

In any field toward which our attention is drawn, certain aspects of that field will stand out in a figure/ground relation to other aspects. Which aspects of the field become figure and which become ground will relate to our expectations of the situation and to our current and most pressing preoccupations and intentions. These will also both be affected by and affect the language games through which we customarily operate. Discussing figure/ground phenomena in a chapter on perception, Adcock comments that, "... detail is observable in the portion regarded as figure whereas the background tends to be rather homogenous." (Adcock, 1964, p. 142)

> A friend of mine, many years ago, bought a Victorian drawing which was a rather skillfully executed reversible figure/ground picture of the type freguently used in works on the psychology of perception. The picture could be seen either as a naked young woman or as a collection of gaunt human skulls. The friend had only seen the former figure and was unable to see the latter until some time after it was pointed out. He was looking absentmindedly at it several days later when suddenly he was able to see the skulls for the first time. Clearly, in such a drawing, the emergence of either subject depends on two totally different interpretations of which lines and which areas of shade constitute the figure against which all of the rest then goes to make up the ground. The two subjects cannot exist simultaneously for any one observer (although they can rapidly be alternated between, once you have developed the hang of it). (Cade & Hudson O'Hanlon, 1993, p. 27)

Troubled people tend to see and remember those aspects of their lives that confirm their problem-saturated sense of themselves or each other and which thus stand out as the figure against which everything else becomes the ground. Also, whether seen as residing in the individual, the family or in any other system, problems tend to be the focus of considerable preoccupation by the symptom

bearer, his or her intimates, and often of other systems - legal, medical, school, psychotherapeutic, neighbourhood, work, and so forth. These preoccupations will be embedded in family, community or professional language games that consist of explanatory frameworks, affective responses, and behaviours for dealing with the problem and its various effects. This will mean that particular events, attributes, etc. associated with problems will stand out as figure against which other possibilities will become ground. As the problem becomes embedded it is as though a gestalt develops in which certain behaviours and beliefs, attitudes and responses are continually being highlighted and repeated and thus reinforced within an interlocking web of language games.

There is an ever burgeoning number of models of therapy (one recent estimate puts the number as over 250) with differing ways of explaining the development of problems, the relationship between problems and past, present or future aspects of people's lives, or their inner and outer worlds, and with sometimes widely differing ideas as to what is the proper focus of attention for the therapist and the therapy. Each approach will have its own language game and, whilst there may well be "family resemblances" between the games, it cannot be assumed, from approach to approach, that terms used in common have the same meanings and carry the same implications. Many a primary worker with a case will be familiar with the feeling of total confusion and even of paralysis that can follow the experience of discussing their client(s) in a multi-agency, multi-disciplinary case conference.

Miller and de Shazer (Miller & de Shazer, 1998) differentiate between the language games that are involved in creating stories about problems as opposed to those that are concerned with helping clients construct stories about solutions. The former tend to focus on deficits, on what is wrong and to become part of a discourse that "constructs" and maintains a problem, and also tend to be past-focused. The latter tend to focus on client resources available for constructing solutions and on what is possible, to emphasize what can be defined as already working, and also tend to be future focused. In many of the former, it is also assumed that there is a direct correspondence between things and events and the words that are used to describe them: he **is** depressed; she **has** a personality disorder; this cluster of symptoms **confirms** a diagnosis of schizophrenia; this family **is** dysfunctional. The latter would show no interest in such catagorization and would see such labels as saying as much if not more about the catagorizer than about the categorized.

Miller and de Shazer also differentiate between the language games used when therapy is seen as a job to be done, defined by what the client specifically seeks help with, to be evaluated in terms of whether it effectively does that job for the client, as opposed to those where therapy is linked to an over-arching explanatory theory, an ideology or a cause such that the client is encouraged to view themselves differently in relation to personal, political, social or cultural patterns identified as important by the therapist. Solution-focused therapy, with its primary concern with what are the therapist attitudes and behaviours associated with most rapidly and effectively bringing about the sought for (by them) changes in clients' lives, clearly falls within the former group.

Who Wants What?

> "*The customer is always right.*"

In the tradition of the work of the Brief Therapy Center, Palo Alto, close attention is paid to who wants help, with what, and for whom? Much of what is often seen as 'resistance' in clients is the result of a therapist failing to clarify whether somebody is a customer or not or, if they are, failing to clarify and respect exactly what it is that they are a customer for. They thus try to 'sell' something to a person who is **currently** not interested in buying anything, or they try to sell the client something other than what they have come in to buy. It is thus important to establish at the beginning whether it is the client's concerns or the concerns of some other person(s) that has led to them being there. If the client is there because of their own concerns, then the therapy can proceed with the job of establishing what those concerns are and what needs to happen for the session to be useful. Where the client has come because of the concerns of others, a respectful acknowledgement by the therapist that they are not there initially out of there own choice can often lead to the beginnings of a productive discussion (which might then lead to the development of an agenda for therapy or to a joint decision not to proceed).

“What brings you here?”

“My doctor thought it would be useful for me to come and talk about some things.”

“Did you agree with him that it might be useful?”

“I don’t know.”

“What do you think your doctor hoped would happen by your coming here and talking?”

“He thinks I need grief counselling to help me get over the death of my mother.”

“Do you agree with him?”

“I don’t know. I don’t like to talk about it. (pause) I don’t know if I want to.”

“When did she die?”

“About a year ago.”

“What do you think makes him think that you need grief counselling?”

“Well, I’ve been depressed and not been sleeping too well, and I burst into tears at the slightest thing. I’ve not been able to work since I broke down earlier this year.”

“And the doctor feels that this is related to the death of your mother?”

“I guess so.”

“Do you agree?”

“I suppose it could be.”

“Were you close to her?”

“Very.” (Client looks tearful)

“So, your doctor feels that talking about your mother’s death might be helpful?”

“I guess so.”

“What difference is he hoping that talking about it will make?”

“Well, ultimately, that I might get off of these anti-depressants and even be able to go back to teaching. I used to be a primary school teacher.”

“Do you want to go back to teaching?”

“Yes, I’d like to feel that I could.”

“So what would need to start happening different in your life so that you could say, maybe not today but in a couple of weeks or so, ‘I’m glad I took the doctor’s advice and went to see that therapist?’”

“If I could just wake up one morning and find that I’m actually looking forward to the day.”

“Suppose that happened. What would be the most likely small but significant thing you would start looking forward to?”

"Just something simple like going out for a walk and having a morning coffee in Eastwood. Perhaps meeting up with my friend. I've been putting off calling her for weeks, now."

"What else?"

It is important that the therapist never be more enthusiastic than the client about the need for therapy or about a particular outcome for therapy. People will only change in ways that they themselves are a customer for. Often, a client can remain unenthusiastic about working on the goals of the people who have brought or sent them, but develop alternative goals of their **own** that they are prepared to work towards. For example, a young person sent by a teacher because of disruptive behaviour in the classroom may show no interest in changing for the teacher but may well develop an interest in finding ways of getting the teacher off of his or her back. An 'anorectic' is unlikely to want to put on the weight that the referrer wants her to, but may be prepared to work towards getting the energy for completing her university assignments. A 'problem-drinker' may have little motivation for working on his drinking habit but be quite concerned about losing his job, in relation to which goal he may draw his own conclusions about the need to cut back on his alchohol consumption.

At times, a therapist can become too clearly identified with the arguments in favour of a particular change, especially, for example, when operating on the behalf of an agency with statutory powers and responsibilities. Whether that urgency be explicitly or implicitly communicated, the therapist can become the main "customer" for how a client should be or for what a client should do. It then becomes as though the therapist has then colonised the arguments in favour of that change, leaving available to the client only the counter-arguments to the change together with the accompanying affect produced by those counter-arguments. The perceived rights and wrongs of the therapist's view of how things *ought to be* are irrelevant if the pursuit of those ends has the effect of disempowering the client, increasing "resistance", or further entrenching attitudes.

The woman from the above excerpt agreed to a second appointment and eventually came for a series of sessions with the goal of gradually increasing the number of things she was doing each day which it would be possible for her to look forward to on waking up. Apart from briefly acknowledging the important role her mother had played in her life and her profound sadness about her death, very little time was spent on issues to do with grief (which is not to say that the issue of grief was not important, nor that the woman did not have grief issues to work through; grief was just **not** what **she** wanted to work on in therapy).

Exceptions to the Problem

"Is the glass half empty or is it half full?"

Central to the solution-focused approach is the certainty that, in a person's, couple's or family's life, there will always be exceptions to the behaviors, ideas, feelings and interactions associated with what is seen as a problem. There will be times, even if they only occur occasionally, when a difficult adolescent **does** co-operate; when a depressed person feels **less** sad, when a shy person **is** able to feel more at ease in a social situation, when an obsessive person **is** able to relax, when a troubled couple **resolves** rather than escalates a conflict, when a bulimic **resists** the urge to binge and purge, when a child does **not** have a temper tantrum when asked to tidy its room, when an over-responsible person **does** say no, when a problem-drinker **does** contain their drinking to within sensible limits, etc.. Yet, because they have become immersed in the problem, they tend to see the problem as figure together with all the processes surrounding it, against which everything else becomes the ground. They tend to see what they expect to see and to miss, discount or deny as significant that which does not fit in with their expectations. As de Shazer observes,

> Problems are seen to maintain themselves simply because they maintain themselves and because clients depict the problem as *always happening*. Therefore, times when the complaint is absent are dismissed as trivial by the client or even remain completely unseen, hidden from the client's view. Nothing is actually hidden, but although these exceptions are open to view, they are not seen by the client as differences that make a difference. (de Shazer, 1991, p. 58)

By questioning clients about these exceptions, clients can be invited to recognize and then to build on **what they have already done or are currently doing** that can be framed as successful or, at least, as heading in the general direction of dealing more effectively with the problem, even if it is only one small step in that direction. They are invited, as it were, to examine the ground and to find forgotten or unnoticed details there that can be highlighted and become a new figure.

For example, a harrassed and demoralized parent was describing how her children would **always** ignore or defy her when she asked then to tidy away their toys and get ready for bed. The therapist responded with a hunch,

"But, sometimes they don't?"

"Yes, but not very often."

"What's different about you the times that they **have** done what you asked?"

(After a pause) "I guess it's when they realise that they have pushed me too far."

"How could they tell that?"

(Another pause) "You know, it's funny. I think its when I stop ranting and raving at them and my voice goes very, very calm."

"What else is different?"

"I don't threaten or beg."

"What do you do, instead?"

"I tell them clearly and firmly what I want them to do."

"You mean it's when they realise they haven't gotten under your skin?"

"Yes, I think that's it. They know I really mean it. Once they get under my skin, they know they've got me on the run."

"What else is different about those days?"

"I think it's when I feel generally less harrassed, when I feel I've got things done rather than spent the whole day worrying about getting things done. When I feel I've not been able to get on top of the housework, I tend to panic."

"So, what's different about those days when the kids do take note?"

"I get started early on and get things done. Then, I can have a break and relax a little before the kids come home from school. I think that helps me handle things better."

"So, on those days, its clear to the kids that you mean business? They must be able to pick up the vibes? You presumably look somehow different on those days?"

"I guess so. Yes, I'm sure that's it. I think I just look calmer."

"What else?"

"I probably greet them more enthusiastically and smile more."

"And when is the last time you had a day like that, or at least part of a day like that?"

"In fact, now I think about it, it happened last Monday. I also took them to McDonalds."

The extent to which a recognition of the existence of exceptions might start a different language game and become a springboard from which further changes can occur, clearly relates to the extent to which they are seen as meaningful to the client. As Cade and O'Hanlon have commented,

> Clearly, it would be easy to highlight exceptions in such a way that the client or family feels patronized, or feels that the therapist really does not understand the seriousness of their problem, or the distress, guilt, anger, etc., that it has caused them. Thus it is important that the therapist avoids becoming over-preoccupied that a client or family **must** recognise the existence of a particular exception, or avoids entering into an argument with them about its significance. As John Weakland has said (personal communication), "Never argue with a client." It is often much better to maintain a puzzled scepticism rather than a crusading zeal. (Cade & Hudson O'Hanlon, 1993, p. 98)

When clients are talking about their problems in a negative, problem-focused way, the therapist can most usefully aid the process of deconstructing that language game by being not too quick to understand. de Shazer has commented,

> ... perhaps the best that therapists can do is creatively misunderstand what clients say so that the more useful, more beneficial meanings of their words are the ones chosen. Thus, creative misunderstanding allows the therapist and the client to together construct a reality that is more satisfactory to the client. (de Shazer, 1991, p. 69)

"I am **still** puzzled as to how you managed to avoid **totally** losing your temper. It can't have been easy. Many parents would have lost it within the first few seconds. Your daughter really does sound as if she could try the patience of a saint. So, how the hell did you resist wringing her neck last night?"

"From what you have told me, I think anyone, including me, would have become depressed. How did you manage to keep yourself going? How did you manage to get on with what you had to do inspite of feeling that way?"

The asking of questions such as, "How did you do that?" can be very powerful. Not only do they implicitly highlight success, or degrees of success, but can also help elicit contingencies in people's lives that are, and can be highlighted as, associated with more successful functioning. For example,

"When was the last time you went a day or more without bingeing and purging?"

"It was quite some months ago."

"But you can remember that time?"

"Yes"

"How did you do it?"

"It was difficult. I managed to hold off for nearly a week. Mind you, I kept thinking about it all day long."

"Of course, but how did you manage it?"

"I was determined not to let it control me."

"How did you manage to do that, and for nearly a week?"

"Well, one thing I did was, after eating, I made myself go for really long walks with the dog."

"And that helped?"

"Yes, because, by the time I got back, I would feel less bloated."

"What else helped?"

"I wouldn't be sitting there with my parents watching and waiting: watching me out of the corners of their eyes, but pretending not to; and me getting more and more angry."

These questions are not part of a fact-finding mission, a hunt for the truth. They are an invitation to the client to enter a language game about themselves and their circumstances that allows for a different view of competence, of possibilities, of their potentials to develop solutions, of the inevitablity of change. So the question "What else ... ?" is used frequently either when looking at past or present exceptions or, as will be seen, when looking at how the future will be different.

It can also be affirming of people when the difficulties they have been struggling with are attested to by questions such as,

"Given what you have told me about your situation, I am really surprised that things are not much worse. How have you kept going?"

As Miller has observed, "By asking how a client has been able to make some progress, or maintain or prevent their problems from becoming worse, the therapist and client are able to re-view situations that appeared to be failures as solutions that simply went unnoticed." (Miller, 1992, p. 7)

However, the usefulness of concentrating on exceptions, on solutions rather than on problems and of using the miracle and scaling questions to be described below, still exists primarily in the experience of the client. It is always important to read the feedback. Some clients want to talk about their problems, to seek an understanding of why they have them, to have an opportunity to "let off steam". Although the ultimate direction of therapy will be to look at what will be different in the future, it is no good if the therapist rushes ahead and leaves the client(s) behind feeling puzzled, unheard, even angry. Clients know best what they find helpful.

The Miracle Question

A powerful way of helping people to focus on potential solutions rather than on problems and to set goals is the miracle question. It continues the process of developing a language game between therapist and client(s) from within which possibilities and probabilities of future success can be both anticipated and constructed. The client is implicitly invited to ignore the details of the problem, in fact completely to bypass them and go straight into the future to a time where the problem either no longer exists or is being handled more effectively and to describe that future in as specific a way as possible. The asking of the miracle question is usually prefaced with a comment such as, "I'm going to ask you a strange kind of question".

> "Suppose that tonight after you go to sleep a miracle happens and the problems that brought you to therapy are solved immediately. But since you were sleeping at the time you cannot know that this miracle has happened. Once you wake up tomorrow morning, how will you discover that a miracle has happened? Without your telling them, how will other people know that a miracle has happened?" (de Shazer, 1994, p. 95)

Clients are then encouraged to elaborate, in as detailed a way as they are able, what the observable differences will be.

(Wife) "I'd be happy; feeling at ease at last. I'd be more pleasant to Bob, not jumping down his throat all the time."

"What will you do instead?"

(Wife) “Well, there would be more understanding between us. We’d listen to what each other was saying.”

(Husband) “Yes. At the moment we don’t really listen to each other. We just wait to get our own point in.”

“So, you’d both be listening to each other more instead of behaving like politicians?”

(Both) “Yes.”

“How could you tell that the other is *really* listening?”

(Wife) “In the face, I think. We’d perhaps make more eye contact. (pauses, then laughs) We’d nod in the right places.”

(Husband) “Yes, we’d both respond to what the other was saying rather than just attacking or ignoring it.”

“What else would be different about the way you talk together?”

(Husband) “Our voices would be different. We wouldn’t be yelling, so.”

“How would your voices be, instead?”

(Husband) “Calmer. More tolerant. We might be putting our points firmly, but we wouldn’t be hammering at each other.”

“So, instead of hammering ... ?”

(Husband) “We’d be talking calmly, respecting each other’s right to a different opinion.”

“Going back to the moment you first open your eyes tomorrow morning, what do you suppose would be the very first thing either of you would notice that would tell you things are different?”

(Wife) “He usually wakes up first so, before getting up to make a coffee, maybe he’d kiss my shoulder, like he used to.”

“Suppose he did that tomorrow morning; what would you then do?”

(Wife) “I’d feel good.”

“How could Bob tell?”

(Wife) “Well, if he could see my face he’d probably see a smile.”

(Husband) “And she wouldn’t pull away from me.”

(Wife) “Well, you know why that is.”

(Husband, to therapist) “She always assumes if I kiss her that I am after sex.”

(Wife) “Well, you usually are.”

(Husband) “Now, you know that’s not true.”

“So, Bob, how would you kiss her so that she would know it was different from an ‘I am interested in sex’ kiss?”

(Husband) “I’d just kiss her gently on the shoulder then go off to make the coffee.”

“Is that what you mean, Tania? Is that the kind of kiss you would respond to with a smile?”

(Wife) “Yes, if I knew it was that kind of kiss.”

“Then what would happen?”

(Wife) “Well, If I knew it wasn’t automatically going to lead to a grope and to ‘wishful thinking’ time, I’d like to cuddle up to him for a while some mornings.”

“How would that make a difference to you?”

(Wife) “Well, it would be a nice way to start the day. Maybe I wouldn’t be so tense and irritable.”

“What difference would the children notice?”

(Wife, laughing) “I wouldn’t be so tense and irritable.”

“What would they see, instead, that would tell them that something had changed?”

(Husband) “If we were talking to each other instead of basically ignoring each other; if they saw us smiling and touching each other affectionately; if they saw us kiss when I left for work; they’d definitely see that something had changed.”

“Is that right?”

(Wife) “Yes. Just us all having a pleasant breakfast together would be a nice change.”

Often, the first answer to the miracle question is a somewhat general, global, even Utopian one.

“I (we) will be happy.” “I will be more confident.” “I will be tall and blonde.” “I will have my sight back again.”

It is very difficult to do ‘happy’ or ‘confident’ (let alone suddenly become tall or regain one’s sight). The level of description that is being sought is something specific that the client could do **even if they didn’t feel like it**. For example, a young woman diagnosed as anorectic found it extremely difficult to answer the miracle question other than saying that she would know it had happened because she would wake up feeling happy. It took the whole session of patiently returning to the question for her finally to come up with two specific differences.

First, she would be able to look in the mirror on her way to the shower without being repulsed. The very fact that she looked in the mirror at all would prove that a miracle had happened because she could not normally stand to look at herself. Second, after her shower, she would go to her closet and choose something to wear because she liked it rather than automatically putting on her “anorectic uniform” of jeans and a bulky sweater.

She came to the next session wearing a short, sleeveless summer dress. It was not that the weather had suddenly become hot. It had been extremely hot and humid for many weeks. As O’Hanlon and Weiner-Davis have said, “It appears that the mere act of constructing a vision of the solution acts as a catalyst for bringing it about.” (O’Hanlon & Weiner-Davis, 1989, p. 106). Looking in a mirror or wearing a summer dress was something she could do, **even if she didn’t feel like it.** Feeling happy was not.

Sometimes a client can find it easier to describe what other people would notice than what they themselves would. For example,

"I would be more confident."

"What would you do differently that would show that you were more confident?"

"I don't know. I just would feel more confident."

"O.K, so when you catch the train to work tomorrow morning, suppose there is someone who travels regularly on the same train who looks over at you and thinks, 'That young woman looks far more confident today.' What would they be noticing different about you?"

"That I would be holding my head up. I would be looking around and showing an interest in things."

"What else?"

"There would be a spring in my step. If it was someone who travels regularly on the same train, I might smile and nod a greeting to them."

"What else?"

"Instead of clutching my bag to my stomach, I might place it on the floor beside me."

Often, the client's initial response will be "I don't know." However, it is very rare to come across a client who cannot, with minimal prompting, begin building a picture of an alternative future.

Sometimes, clients do find it difficult to imagine that a miracle has happened. Whilst it clearly is important not to push too hard for an answer, a gentle and respectful persistance over the course of an interview can help begin the process. For example, a woman who was struggling with two oppositional adolescents found she could not answer the miracle question. As she continued to describe the difficulties she had been experiencing, she told of a recent incident in which they had made her "lose the plot."

"Suppose that miracle I talked about earlier had happened. How do you think you might have handled that situation differently?"

"I guess I maybe would have walked out of the room and calmed myself down, first."

"What else might have been different?"

"I wouldn't have risen to the bait in the first place. They really know how to wind me up."

"So, after this miracle, the kids will learn that you are not so easy to wind up?"

"Yes."

"What else would they learn?"

"Maybe that I deserve some respect."

"What will they see in you that will tell them that you deserve respect?"

People typically find it easier to define how **other** people should be different (particularly the spouse with whom they are having difficulties, or a problem child). This can tend to perpetuate a more of the same "why can't you see what you are doing wrong", stance which will often be insufficiently different to their usual interactions around the problem. It is better they be encouraged to describe what differences others such as their spouse, children, friends, work associates, or strangers will notice about them.

> "Suppose your husband does begin to behave in a more considerate way, what differences will he see in the way you respond to him that will show him that you appreciate it?"
>
> "Suppose you two were to go to a restaurant tomorrow night and another couple was watching you having a meal together, and one of them said to the other, 'that couple look as if they are getting on well', what would they be seeing that would tell them that?"

Often clients describe differences in terms of an **absence** of either a behaviour or an emotional state. It is useful to ask them what it is that they will be doing or feeling **instead**. Ultimately, it is much easier to engage in a clearly defined alternative behaviour than it is just to resist doing something without having another activity to take its place.

> "So, when you are no longer sitting around crying and feeling sorry for yourself, what will you be doing instead?"

Descriptions of changes in feelings are also best translated into descriptions of the specific behaviours that would be clear evidence to others that their mood had changed.

> "What specifically will your colleagues at work see different about you that would tell them that you were no longer depressed, without you telling them?"

Another way of focusing on the future is to ask a question such as, "Suppose you are coming back next week, and you are sitting there telling me that things have improved in small but significant ways, what is it that you will be telling me about?" , or, when talking to a couple, " ... what will be the differences in you that your partner will be telling me about?"

When working with young children, it may be that the notion of a miracle is not one they will easily understand. It is always possible to use notions such as a magic wand, a good fairy, a guardian angel, a fairy godmother, a genie, Sabrina the teenage witch, etc..

Scaling Questions

> *As anyone who has played around with numbers knows, like words, numbers are magic.* (de Shazer, 1994, p. 92)

Another important part of the solution-focused language game is the use of scaling questions, which can be used in a wide variety of ways. Scales of some sort or other have been used in many other approaches to therapy, usually as a way of measuring aspects of a client's behaviour against some normative standard. In solution-focused therapy, scales are used to create (and reflect) an assumption of fluidity and change. They are a measure of a client's perception of themselves **now** compared to how they had been before and how they would wish to be. They have no external referents other than those that are meaningful to the client (even if they are not clearly able to articulate them). If it were hypothetically possible to have two people at exactly the same point *vis a vis* solving exactly the same problem, one of them might scale themselves at 4, the other at 7. Neither would be right or wrong. The usefulness of the scale is totally subjective and solely in terms of whether the number chosen helps each client have a sense that they are handling things better now than at some earlier point, and helps them develop a sense of moving forward, or the possiblity of doing so, and a picture of what things will be like when that forward movement has been made. As Kowalski and Kral have pointed out,

> ... the scale builds on an assumption of change in the desired direction. Since a scale is a progression, the number '7' assumes the numbers '10' as well as '5', '3', or '1'. It assumes movement (change) in one direction or another , rather than stagnation. By virtue of this, an expectation of change is built into the process of asking scaling questions ... since the use of a scale enhances a suggestion of change in either the desired or dreaded direction, it also implies a degree of control on the part of the client for navigating the direction ... the business of goal setting is accomplished, since the poles and the area between the problem and the goal are made quantifiable and objectifiable. (Kowalski & Kral, 1989, p. 61)

Through the means of a scale a precise figure can be elicited that represents a whole range of aspects of the client's experience, with components ranging from the specific to the global, even to the vague. A general sense of how they are doing can be translated into a concrete number which will have meaning for the client. Although it is possible to invite them to spell out some specific things that are happening that tell them they have achieved a particular number, it is never possible to achieve a complete picture. There will always be more, and that creation of a sense that there will always be more is an important part of the solution-focused language game. The most frequently used scale in a first session is as follows.

> "On a scale ranging from 0 to 10 where 0 represents when things were at their worst (in subsequent sessions, it is more usual for 0 to represent the way things were when they first sought help) and 10 represents how things will be when these problems are resolved (or, if the miracle question has already been asked, " ... when this miracle we've been talking about has happened") where would you place yourself today?"

Although there will be clients who will place themselves at 0, a surprising number will place themselves somewhere higher on the scale creating instantly a potential story of flexibility and a degree of success already in dealing with the problem rather than one of its being a monolithic fixed entity over which they have little or no control.

Whatever number the client comes up with (3 is the number that seems most often to be chosen) two areas of expansion then become available. First, the client can be invited to describe how they have got themselves to 3. "How did you do that?" "What are you doing different that you were not doing when you were down at 0?" This will encourage them to concentrate further on exceptions. As highlighted earlier, it remains important that the therapist be cautious not to be more enthuiastic than the client, even potentially patronising, about the importance of an exception. Second, the client can be invited to build a picture of future step-by-step change (as opposed to a sudden miraculous change) through being asked what would need to be happening for them to feel they have moved from 3 up to 4. For example,

> "On a scale ranging from 0 to 10 where 0 represents when things were at their very worst and 10 represents how things will be when your life is fully back on track again, where would you place yourself today?"
>
> (After a pause) "About 3."
>
> "How have you done that? How have you got yourself from 0 to 3?"
>
> "I guess I decided I just couldn't go on that way any longer."
>
> "So, what have you been doing different that has got you from 0 to 3."
>
> "Well, for a start, I contacted you."
>
> "OK. What else?"
>
> "I've been making myself get up and take a shower first thing each morning. Also, on a couple of mornings, I went out for a walk. It was tough getting myself started ... "
>
> "I'm sure it was."
>
> " ... but I tend to feel better once I've done it."
>
> "What else?"
>
> "That's about it. (short pause) Oh, I did try to call a friend, yesterday. But she's away in Brisbane for a few days."

"So, you might try her again, later?"

"I guess so."

"Anything else that you're doing different that tells you you've moved from 0 to 3?"

"I can't think of anything else."

"OK, suppose that we are now a week or two in the future and you are sitting there in that chair and telling me that you feel strongly that you've started edging towards or even that maybe you've reached 4. What will you be telling me about?"

"That I've called that friend and that we're meeting up for a coffee."

"OK. What else?"

'That I am still getting up early and also still going out for walks. (pause) Maybe I'll have started looking in the paper for a job."

"Are you sure that looking for a job would be at 4? That sounds like quite a significant jump to me."

(laughs) "I only said **looking** in the paper. I didn't say anything about actually going for one."

"You're right. I was jumping the gun. So where would you have to be on the scale to be actually going for a job?"

"6 or 7, I guess."

"So, what else would you be doing that would tell you you were at 4?"

"I wouldn't be sitting around feeling sorry fo myself all day."

"What would you be doing, instead?"

"Maybe I'd start painting again."

"Painting?"

"Yes. I used to paint with watercolours. You know, flowers, landscapes and things. I used to enjoy that."

Scales can be used to consider a whole range of aspects of a client's life or of the therapy. In fact, there are few experience that cannot, in some way, be looked at through the lens of a scaling question.

> ... scaling questions can be used to assess self-esteem, pre-session change, self-confidence, investment in change, willingness to work hard to bring about desired changes, prioritizing of problems to be solved, perception of hopefulness, and evaluation of progress, and so on - things usually considered too abstract to quantitate. (Berg, 1994, p. 102)

The following are some examples of scales that can be used,

(To a couple) "If 0 represents 'I couldn't really give a damn' and 10 represents 'I'm really motivated to work on our relationship', where would you place yourself today between 0 and 10? (or , " ... where do you think your partner would place him/herself?"). What will have happened over the next week or so for each of you to feel you have moved up a point or two?"

"If 10 represents 'this relationship has the potential to be a really good marriage' and 0 represent 'this relationship has no future at all', where would you put yourselves today between 0 and 10?"

"If 0 means you believe you are basically going to be like this for the rest of your life and 10 that you are very confident that you'll have this problem beat at some point in the future, where would you place yourself on that scale today? What would it take for you to move up half a point or even one point on the scale?"

"If 10 represents having as much confidence as anyone could expect to have, and 0 is the opposite, absolutely no confidence at all, where would you put yourself today?"

"If 0 represents how you were when I first met you and 10 represents when that miracle we talked about has happened, where are you today between 0 and 10?"

"If 10 represents that you'll do more or less anything to get over this, and 0 represents that you're only prepared to wait it out and hope it will all go away, where are you between 0 and 10, today?"

It is important when enquiring about movements up the scale that the therapist choose realistic gradations erring on the side of the conservative rather than the over-optimistic. If a client is experiencing a high degree of optimism, it is better that he or she has to persuade the therapist about that. If the therapist seems to be pushing too quickly for change such that the client feels pressured, he or she is more likely to adopt a "yes, but" position.

Looking at a client's progress through the medium of a scale can often give him or her a different perspective on how things are going. A young man apologetically admitted that he felt he'd only reached three on the scale. He was surprised and encouraged when it was pointed out to him that he was "almost a third of the way there." A young woman who was still expressing many negatives about her progress, in spite of the many "exceptions" the therapist had been able to elicit (which were clearly, at that stage, more meaningful to him than to her) became more optimistic about her situation when, after scaling her overall progress as 5, she realised she was "halfway there".

Scaling questions can also be used with young children as well as with adults. Words are, of course, not the only medium to be used. The therapist can draw pictures, or ask the child to draw them. There are many creative ways young children can helped depict where they feel they are. A young girl who had been sexually abused was invited to draw a picture of herself that showed the way she saw herself now and then a picture of how she would look when she really liked herself. She first drew an ugly, distorted figure in brown and black, covered with spots and with a miserable mouth. Her second picture was of a pretty girl wearing brightly coloured clothes and with a big smile. She drew flowers around the feet and a sun in the sky. It was then possible both to talk about and to draw the small changes that would tell her and her friends that she was moving from the one picture to the other.

> As I struggled to find a way of expressing a scale that would be meaningful for her to help her envisage and measure her progress from being the girl in the first drawing to the girl in the second, Melinda came up with a wonderful insight which also provided us with an evocative scale. She said that getting better was a bit like being in a game of snakes-and-ladders. As you moved forward you sometimes went up a ladder and felt that you were beginning to get there. Then, every now and then you would slip down a snake. Some days you would feel that you had gone up one of the big ladders and things were really good. "Then you slide down that bloody big snake and feel you've gone right back to the beginning again". She put a hand over her mouth realising she had cussed. I told her that it was alright; that I used to be a truck driver and was not easily shocked. She went on to say, "But you mustn't let yourself get too upset because, if you keep on going and don't let sliding down the snakes upset you too much, everyone gets to the finish in the end."
>
> From that time on, each session I would draw a snakes-and-ladders board and Melinda would indicate what her position was on the board that represented how good she felt about herself on that particular day. She agreed with me that the difference between snakes-and-ladders and real life was that, in real life, you could often make your own mind up about how you wanted

> to act and react, although sometimes it was difficult not to “slide on down that snake”. I suggested, both at school and at home, that she keep a watch out for any time that she could easily have slipped down a snake but didn’t and did something else instead. (Cade, 1998, p. 8)

The Intermission

Solution-focused therapists typically take a break before ending each session, whether or not there is a team behind a one-way mirror with whom to consult. de Shazer describes the beginnings of this tradition,

> One day in 1977, we watched while the therapist and client were trying to define and describe the problem, i.e., the client's complaint and the associated, failed attempts to resolve that complaint much in the same way that MRI would do it. The client and therapist were focused on this frame: She was depressed and, therefore, she was fat. Naturally she believed she needed to stop being depressed before she could lose weight. Behind the mirror, the group was thinking the opposite: She's fat and therefore she's depressed. Using that punctuation, interventions could be aimed at her ways of accidentally maintaining and increasing her weight. We phoned in a couple of suggestions based on this view but the therapist did not find our help helpful. This frustrated both the therapist and the group. Finally, the therapist excused himself for a couple of minutes to talk to the team. He was going to straighten us out. I don't remember the outcome of that discussion, but we soon started to routinely take a break in the session during which the team and therapist would meet, a procedural intervention that we continue to this day. It was not long before we started to take a break "to think about things" even when working alone. (de Shazer, 1999)

Before leaving the room, however, it is important that the therapist ask whether there is anything that so far has not come up in the session that the client feels it is important he or she knows about at this point. Sometimes a client will then bring up an issue that is important and which may require further clarification before the break is taken. At times, a client will bring up an issue that may not seem particularly relevant to the therapist. However, it remains important to ask the question. If this is not done and the client believes there is something important the therapist should know, or should have asked about, then whatever the therapist says to end the session will become diluted or lost behind the client’s sense that the therapist lacks (or has shown insufficient interest in) this important knowledge.

A break allows the therapist to collect his or her thoughts, to compose a concluding statement, to construct an appropriate homework assignment and, of central importance, to make sure that all of the former relate to what was the client’s primary expressed concern. An interview can range over a wide number of issues, many of which may be of intense interest and concern to the client but that are **not** the central concern that brought them to therapy. It can be easy for the therapist to frame the concluding comments and the task around one of these issues (particularly if it is an issue about which the therapist holds strong views) rather than around the specific concern that brought the client there. This can lead then to “resistance” on the part of the client.

A break also gives the client time to think about the session and heightens his or her sense of anticipation about what the therapist’s (and, where relevant, the team’s) opinion and suggestion is going to be. Also, clients often come to therapy expecting to be probed and exposed in areas of their greatest doubts or emotional sensitivity and/or to be “told the error of their ways”. The break brings the realisation that this is not about to happen.

For example, a woman remained both verbally and non-verbally totally unresponsive throughout the whole of a first session. She had had two previous experiences of more traditional therapies during which, according to her husband, she had also been totally “uncooperative”. The therapist was careful not to try to persuade her to respond, though she would ask the woman the occasional question. However, she was careful, when receiving no response to a question, not to turn to the husband for the answer, but would ask him a totally different question, thus avoiding the trap of seeming to enter a “co-therapy” relationship with him. When the therapist returned from her break, the woman instantly and spontaneously began to respond, firstly with silent nods of agreement at the validating feedback, then verbally, and finally laughing and joking. It is interesting to speculate on the

importance of the break to let this woman know that the pressure to respond she had doubtless been anticipating from the therapist was actually not going to occur.

Summary, Compliments and Tasks

A solution-focused therapy session always ends with a final intervention which includes a summary, compliments and, following on logically from those, a task, often described as an experiment.

The final summary first of all indicates to clients that they have been listened to and understood. People tend to hear best when they feel that they themselves have been heard. It therefore clearly must address their primary concerns. It should acknowledge the difficulties they have been struggling with and the positive attempts they have made to deal with the situation. It can be helpful and affirming, where possible, to reproduce or paraphrase a client's own language, including the idiosyncratic ways they use particular words or phrases. Consistent with the development of a solution-focused language game, this summary should concentrate on complimenting positive aspects of a client's achievements, intentions and desires. It must obviously be sincere and avoid being either glib or patronizing. Client goals should be identified and validated as important and worthy of the hard work that might be necessary to achieve them. As Berg and Miller point out,

> The team at the Brief therapy Center has been using and studying compliments for close to 20 years, and we continue to be amazed at their therapeutic power and usefulness as an intervention tool. The compliment is used with all cases ... regardless of the type of client-therapist relationship, and throughout the treatment process. Except on rare occasions when the client is squeamish about receiving compliments, and in extremely rare situations where the therapist is unable to find anything positive at all, we find that using compliments enhances the cooperation with the client. ... The use of compliments is one of many tools a therapist has at his disposal that takes advantage of socially accepted norms of discourse. We discovered through our cross-cultural and international presentations that all cultures use compliments as a means to cementing social relationships at all levels. However, the cultural norm dictates the manner in which compliments are presented. (Berg & Miller, 1992, pp. 101-2)

The task that is then suggested should follow logically and naturally from themes highlighted in the summary. "Because it is so clear to us that ... " or "because it is obviously important to you that ... " A critical reason for giving an assignment to be carried out between sessions is that it emphasises therapy to be primarily about helping the client do things differently out there **in the real world** rather than some process that takes place in the therapy room. Also an important thing about giving a task that encourages people to engage in different behaviours is that it has been shown that when people engage in particular behaviors associated with, or promoted by, particular beliefs or attitudes (the new language game), commitment to those beliefs or attitudes becomes confirmed or strengthened more quickly and profoundly than from just talking about about them (Kiesler, 1971). Clearly any task that is suggested must be seen to be relevant to the concerns that brought them there, and seen to make sense.

The most frequently suggested task is one that requires the client(s) to observe between this session and the next whatever it is that they do that moves them one step up a scale (whichever scale seems most relevant, given their primary concerns). They are not asked to try to make the changes, just to notice when they do. This is part of a language game in which change in the desired direction is assumed to be inevitable, the task just draws the clients attention to this. A figure/ground reversal is thus made such that clients are more likely to notice naturally occuring exceptions that otherwise would probably remained hidden.

The following is an intervention given to a young woman who, following a breakdown during her final year at high school, had been embroiled in the psychiatric system for three years. This also included three periods of in-patient treatment. Over this time, she saw herself as having been passed from one worker to the next with nobody seeming to care or wanting to listen to her side of the story. Earlier in this first session, she had put herself at 2 on a scale in which 0 represented when things were at their worst and 10 represented when her miracle had happened. Her reason for coming into

therapy again was her wish to "get her act together" and to move back into some kind of basic education.

"First, let me say that I think it was courageous of you to come here, today. After all you have been through, to take the risk of coming to see yet **another** therapist took guts, and also tells me that you are very serious about wanting to get your life sorted out. And, the way that you **really** checked me out at the beginning of the session!!! You seem to know pretty clearly what you are looking for, and it's also clear that, in future, you are determined to make your **own** mind up about who you will see and who you won't see, and when. Have I got that right?"

(Client) "That's it. I've **really** decided I'm **not** going to be pushed around, anymore."

"From what you tell me, you have clearly had a difficult life with lots of losses and a whole heap of terrible disappointments. However, you are still wanting to get your act together and to go back to studying. You still want to catch up with the education that you lost out on back then. That's impressive! After years of feeling pushed from pillar to post and being given drug after drug by people who you feel did not listen to what you **really** wanted, you still have this level of determination. That **is** impressive.

"You obviously are aware that getting your HSC (Higher School Certificate) will take a lot of hard work, but you clearly think it is worth the effort. I agree that the effort, however hard it may be, could set you up for a better future. But you are also aware of your tendency easily to be discouraged if things do not go exactly as you would wish. This important insight could hold you in good stead when the going gets tough. As you said earlier, that's when the tough get going.

"Because you are clearly **so** determined, and because you seem to recognise the importance of not biting off more than you can chew, otherwise you can easily become discouraged, I have a suggestion for you to try by way of a sort of experiment. Then, if you would like to, we can set up another appointment. Is that O.K?"

(Client) "Yes, I'd like to come back."

"I would, first of all, suggest you be careful of shooting for 10 straight away. Shooting for 10 tends to mean you only end up seeing how far short you fall. Do you know what I mean?"

(The young woman nods)

"Between now and the next time we meet, I would like you to make a mental note of what you do that begins to move you from 2 up to 3 on that scale we looked at (I'm not asking you to write it down but, of course, you can if you would find it easier). I am particularly interested in small steps. I am sure you know the story of the tortoise and the hare."

(The young woman nods)

"It's always the tortoise that gets there first by taking small, steady steps. So, notice anything you do, any way that you respond differently, that tells you that you have begun to move up from 2 to 3. If on any day you go higher than 3, enjoy that day as a bonus but be careful not to judge the next day by that higher number. O.K?"

(Client) "O.K."

"Do you have any questions you want to ask about this?"

(Client) "No, I don't think so."

"Let's set up another appointment. What do you think would be a good gap between now and the next session so that it is not too close but also not too far away?"

(Client) “A couple of weeks?”

“O.K.”

Although the timing of subsequent appointments often has to fit into real limitations imposed by worker or agency schedules, where possible, the client should be asked both whether they want another appointment and, if so, when. It should not necessarily be assumed that a second session is either wanted or needed. Therapists tend to see therapy as, by definition, invoving a series of sessions; clients do not necessarily do so. Working in a medical center, Moshe Talmon looked at why so many of his clients did not return for second interviews. As he observed,

> In spite of my fears about what I would hear, the results of my follow-ups seemed almost too good to be true: 78 percent of the 200 patients I called said that they got what they wanted out of the single session and felt better or much better about the problem that had led them to seek therapy. (Talmon, 1990, p. 9)

He also examined the practice of colleagues employed in the center, including psychiatrists, psychologists and social workers, to find that clients not returning for a second session was far from uncommon. He also found that “ ... the therapeutic orientation of the therapists had no impact on the percentage of SSTs in their total practice” (p. 7). In a subsequent, more formal research project, 88 percent reported “much improvement” or “improvement”, 79 percent found the one session to have been sufficient, and 65 percent had experienced changes in areas other than those for which they had initially sought therapy.

There are a wide range of different tasks that can be suggested limited primarily by the particular style and creativity of the therapist and (where in use) the team. People new to the approach often become fascinated by some of the tasks they see in demonstration interviews or that they read about, and often become preoccupied with coming up with similar ideas. It is important to keep in mind that the moxt important part of any intervention is the the first part where the therapist summarises and compliments the client and agrees with their goals. If that first part is not adequately addressed then the best task in the world is likely to be ineffective, whereas a well thought-out, confirmatory summary may well make a significant contribution to a client making changes even though no task is suggested. After all, much of the outcome research has suggested that a client’s positive feelings about their encounter with the therapist, and their experience of feeling heard and understood, are major predictors of a positive outcome to the therapy, while our techniques make a much more modest contribution (Miller, et al., 1997).

A useful class of tasks are those in which the client is asked, at particular times between one session and the next, to pretend that a desired change has occured and to observe what difference it makes to both their behaviours and to the ways that significant others respond. For example, a woman strugging with a difficult 6 year-old, had identified a heavy legacy of guilt from the past as underpinning much of what she described as her inadequacy as a mother. It was suggested that on dates with even numbers she should pretend to herself that she had had a “guiltectomy” and see how it affected the way that she handled her daughter and the way that her daughter responded to her. On the dates with odd numbers she was to go about things just as she normally did.

de Shazer describes such a task given to a troubled couple, both with long psychiatric histories,

> We have some ideas, an experiment we’d like you two to do between now and next time we meet.
>
> Each of you pick two days over the next week, secretly, and on those days, we want you to pretend that that miracle we talked about has already happened. OK?
>
> And observe how the other person reacts to what you do. Then, see if you can figure out which two days she picks, you see if you can figure out which two days he picks. Don’t say anything about it. Do it secretly, just observe. Observe how he reacts, observe how she reacts. You might even pick the same day by accident; that’s OK. You might learn something extra

> that way. But it has to be by accident. It's got to be a secret; don't discuss it. (de Shazer, 1991, p. 144)

An interesting variation on the above is to suggest that the client toss a coin each day. When it comes up heads, for example, the client is to carry out the suggested experiment and when it comes up tails, they are to behave as normal. It is interesting how often people change their behaviours on the days when they do not have to change. For example, a young woman was making herself ill by obsessively over-studying for her final exams. She had had literally to be carried out from a trial examination, violently sick with anxiety and exhausted. Although she knew she had already done enough preparation to pass with high grades, she was finding it impossible to relax. It was suggested that, each day, she toss a coin. If it came up heads, she was not to do any work at all on that day, however hard that might be. She was to go to the beach or do something similar and to be sure to take no text books with her. If it came up tails, she could study as hard as she wanted. It is interesting that she found it difficult but possible not to work when the coin came up heads, but easy to work in moderation when it came up tails.

Berg and Miller have described the use of a prediction task in situations where the client feels there is no pattern to, and that they have no control over, the occurrence of problems.

> Between now and the next time we meet I suggest the following: Each night before going to bed, you make a prediction about what kind of drinking you will do the next day and keep a record of it. Next day you go about your day as usual but at the end of the day compare your activities with your previous day's prediction to see whether or not your prediction came true. Also, jot down on a piece of paper what diffences you noticed about your life. Then make another prediction for the following day. We would like you to repeat this for a week and come back with the results. (Berg & Miller, 1992, p. 126)

In situations of extreme client pessimism, it is possible to summarise how extremely difficult things have been, to declare that, given what has happened it is surprising that things are not much worse, and to ask the client to pay particular attention to what they do between now and the next session to keep things at the level they now are (or at whatever point on a scale they have put themselves) and to prevent things becoming worse. As scales are purely subjective entities, where a client places themselves at 0, it is possible to ask about how they have prevented themselves from going sub-zero.

As I have already indicated, people will usually only follow suggestions if they are a customer for change and if the behaviours they are being asked to try are consistent with their ideas about how they want to be, rather than how the therapist or some other person wants them to be. However. sometimes a client will accept an odd, even a bizarre, suggestion, even one they do not fully understand the reason for. This tends usually only to happen where they feel profoundly understood, respected and positively engaged with the therapist.

For example, an 18-year old, "bulimic" young woman was somewhat demoralised after what she described as the lack of success of a previous therapy. She talked about her symptoms with a very serious demeanour. She had been advised that her condition would require prolonged and intensive therapy. Having made a positive initial connection with her, the therapist asked her suddenly whether she had tried any creative experiments with different foods to see if they made different patterns in her vomit. She burst out laughing and said she hadn't. The therapist went on to ask her if she had tested the Scottish comedian, Billy Connelly's hypothesis that, whenever you vomit there is always some diced carrot in it even if you haven't eaten carrots for months; that they must lurk around waiting for you to be sick. She again burst out laughing. At the end of the session she was asked if she had a good sense of humour. She said she did and the therapist confirmed that it was certainly his impression that was the case. She was then asked whether she would be prepared to try an experiment that had a touch of absurdity to it. She said she did not mind being absurd. "Or looking absurd?". She was happy to go ahead. It was suggested that, for the next week, whenever the urge to binge overcame her, she was not to waste time fruitlessly fighting it then failing but to go ahead. In fact, she was advised not to try to go a whole week without bingeing at this early stage. However, before bingeing, she should go to her bedroom and put on her oldest clothes, but put them all on back to front. She clearly should not do this with her shoes because this would mean she would have to

dislocate her feet. It was suggested she also buy a cream cake each day and, after eating all that she felt she could eat, she was to finish off with it. Then, before vomiting, she was to go back to her bedroom and change into her smartest outfit and then go ahead with getting rid of the food.

She left the session still laughing and clearly much more optimistic about her ability to deal with her problem.

> A 13-year-old girl was continually being checked up on by her elderly parents. She was seen as untrustworthy, aggressive, lazy, uncooperative and unhelpful. Though the girl showed no motivation to be involved in therapy, she began to express interest when asked by the therapist whether she would be prepared to trick her parents. To this she readily agreed. She was asked to do a number of things over the next couple of weeks that she knew would definitely please her parents. However, she was to do them in such a way that they did not know what it was that she had done. Neither was she to let on, even if asked. She was to deny that she had done anything, even if they were to guess correctly.
>
> The parents, meanwhile, were to make every possible attempt to to find out what it was she had done and to keep a written list. They could discuss it together but were not allowed to ask her.
>
> At the next session, the girl was seen separately. She admitted that she had not really made any efforts to do anything but admitted that things had been much better between her and her parents. When the parents were seen, they brought with them a long list of all the things that they had detected that they thought she had done in order to please them.
>
> It seems that, whether the girl undertook her part of the suggestion or not, her normal behaviour patterns contained sufficient non-confrontative, cooperative acts, which perhaps were normally not noticed, to satisfy the parents that things were changing. From the daughter's point of view, the parents' constant vigilance, against which she was normally rebelling, had taken on a new meaning and become an attempt to discover evidence of good rather than bad behaviour. (Cade & Hudson O'Hanlon, 1993, p. 129)

Although the girl in this example had been asked to do something her parents wanted (usually unwise with adolescents), the intervention did not actually require her to comply. More important was the invitation to the parents to look for evidence of cooperation instead of constantly looking for evidence of transgressions. We tend to see what we expect to see. When we treat a person as though they have certain attitudes or traits, they are more likely to exhibit them. A reversal of the usual figure/ground lead to the parents seeing cooperative behaviours that were already happening. The change in her parents' attitude probably also lead to the girl being spontaneously more cooperative without her necessarily having to have any conscious intention to change.

Subsequent Sessions and Endings

It is usual to commence the second (and subsequent) sessions with some variation or other of the question, "What's been better since we last met?" The responses to this opening will range from those who are able to elaborate a range of changes to those who indicate that either nothing is better or that things are worse. However, with a little persistance on the part of the therapist, it is very rare for people not to be able to point to times when **something** in the situation was better, even if only a little and briefly.

"What's been better since last time?"

(Wife) "Nothing. We have had a terrible week."

(Husband) "And we've just had a God Almighty row in the car on the way over here."

"OK. Lets come back to that. Taking the last week as a whole, even if only a little bit, what has been better?"

(Wife, after a pause) "We did go for a coffee after we left here last time, and we talked quite a lot more about things. In fact, for us, we had quite a civilised conversation."

"In what way?"

"(Husband) "We listened to each other. We actually had a pleasant couple of hours."

(Wife) "Then we went home and the wheels fell off, again."

"What else was different about the time over the coffee?"

(Husband) "We were both feeling more relaxed."

"How did that show itself?"

"(Husband) "Well, we were smiling at times rather than frowning."

(Wife, grinning) "We had our knives back in their sheaths rather than plunged into each other's backs."

"What else has been better?"

(Wife) "We went to the cinema the other night. The film was awful, but we had quite a good time, now I think back to it, didn't we?"

"In what way?"

(Wife) "We had a meal before the film, which was quite nice. And we had sex that night; the first time for some weeks."

Such conversations are not to deny that things are still very difficult, but to help people identify the small building blocks that, if there is potential in their situation, will go toward constructing a different future. Also, a recent setback such as the "God Almighty Row on the way over here" that the above couple reported, can often colour the way that the rest of the week is seen. It is interesting how, even when clients say that there has been no change or that things have become worse, these are still only partial descriptions of their situation, part of their problem-saturated language game. Once an exception has been identified, however small, clients will often, over the course of the session, go on to describe others that they had initially forgotten or just not noticed. As they move into the new language game, these small events take on greater levels of significance. Sometimes changes of considerable importance can become hidden under the general picture that things are the same or worse. For example, it was three quarters of the way through a second session, during which he had been describing his situation as no better, that a man "let slip" that he had been offered a job (he had spent many months looking for one). In the case of the couple from the de Shazer example quoted above, who were invited secretly to pretend a miracle had occured, it was some way into the second session that the wife let slip that she had successfully completed her first day as a substitute teacher. The husband, having earlier described himself as floundering throughout the whole of that same day, went on gradually to elaborate a busy day in which a list of small but important chores had been completed.

When changes or exceptions are identified, it is important to amplify and reinforce them. The two questions, "How did you do that?" and "What else?" remain of central importance.

> Eliciting and amplifying the small but significant changes the client has made can be achieved by asking detailed questions regarding the events the client describes. This detailed questioning can easily last up to twenty minutes during the follow-up interview. Asking about

> the chain of events, sequences, and who else noticed the changes also amplifies the positive changes: When did this happen? What did you do? Who else noticed? What did they do when they saw you doing that? What tells you that they noticed the changes in you? What was going on at that place that helped you do things that way? What else did you do? ... What gave you the idea to do it that way? ... Is that new for you? How did that help you? How did that help your family? What did your husband do when he noticed you doing it that way? How did that help him? (Berg & Miller, 1992, p. 132)

It is obviously important when asking such questions to avoid being patronising and also to avoid being more enthusiastic about the changes or their implications than the client. A position of respectful curiosity rather than persuasion appears more effectively to help clients enter the new language game and to draw positive conclusions themselves. The importance of continuing to ask "What else?" is that, as touched upon earlier, many of the behaviours that are involved in the building of a different future and that can be incorporated into a new language game tend to be the small and apparently trivial minutiae of day to day life and thus easily overlooked or dismissed as of no significance.

Scaling questions also help focus on change. A frequently asked question in second and later sessions is "If 0 represents how things were when you first came to see me and 10 represents when things are all sorted out, where would you put yourself today?" Again, as elaborated earlier in the section on scaling, questions can focus on the details of how they achieved whatever steps they identify and then what needs to happen for them to move up one more step on the scale.

When clients continue to say that things are either no better or that things are worse, it is important that the therapist points out that he or she now understands more clearly how difficult and/or complex the situation is. Thus validated, it is surprising how often clients will begin to talk about small changes that have occurred. Sometimes, the feeling that things are no better or even worse may be because the client was looking or hoping for a substantial or even a complete solution and therefore is either not able or prepared to see small changes as of relevance. It is also important that the therapist be sure that he or she had not veered away in the previous session from the agenda that the client had originally come with. If this were to have been the case, then getting back on track quickly is likely to start things moving along.

Interventions at the end of second and subsequent sessions take essentially the same shape as those previously described. It remains important to summarise, to compliment and to suggest a relevant task, maintaining what has been achieved and building on what has changed.

> "I am really struck by the determination you have shown and the changes that you have begun to make. In spite of the difficulties that you are still encountering, you nevertheless have moved from 3 up to 5 on the scale by relaxing more with the children, by cleaning up the house, by making contact with a friend to go out for lunch. This is impressive. Many people know what they have to do but continue to talk themselves out of it. You clearly have not done that this week. You also know that life rarely runs smoothly and that you are going to have set-backs and it is clear that you are ready to tackle them. It is also clear that you feel the future benefits of being more available to your children is worth the hard work. Because this is so clear, what I suggest you do between now and when we next meet is to watch very carefully what you do to keep yourself at 5 or even to begin to creep toward 6, but especially to watch how, if things get tough and you go back down the scale, how you get yourself back up to 5 again."

In this approach to therapy, the end comes as quickly as possible and is defined not so much by the ultimate goals being attained (although that can happen) but by the client feeling that they are now sufficiently on track not to need the therapist's inputs anymore. Clearly, the end is defined by what the client thinks not what the therapist thinks. Often the client will indicate that they do not need another session, that they feel things are now moving along in the right direction. Alternatively, the therapist may see that things have begun to move and can end a session saying something like,

> "It seems you have begun to make some significant steps forward. We can do one of several things at this point. We can make another appointment if you think that will be helpful, or we can

make a time for a couple of months or so away, or we can say 'lets see how it goes' and you give me a call if you would like to meet again."

Applications and Outcome Studies

Over the last decade or so, the solution-focused approach has grown rapidly throughout the world and is used in a wide range of settings. From early on it began to be used in residential settings and in Schools. It is used in mental health settings, in public social services agencies, in hospitals, in the probation service and in prisons, in child welfare. It is used with groups, as an approach to supervision and in institutional or business consultations. It has been used with child and adolescent problems, domestic violence, survivors of sexual abuse, drug and alchohol problems, mental illness, with the physically handicapped, marital problems, multi problem, multi-agency families, the problems of aging, eating disorders, adoptive families and in family medicine. This is, of course, by no means an exhaustive list. For a continually updated list of publications (now over 1,000 items) readers are referred to Patrick Triggiano's comprehensive compilation which is entitled *The Solution Papers Revisited: A Compilation of the Beginning, Integration, And Ever Expanding Guide to Solution-Focused Publications*. This is available on the internet at www.talkingcure.com/solutionfocused.htm.

Over the years that it has been developing the approach, the Brief Family Therapy Center has systematically followed up its clients by contacting them at between 6 to 18 months and asking whether they felt they had achieved their treatment goals or, at least, made significant progress toward them. Results have consistently shown between 70 - 80% answering in the affirmative. (de Shazer et al., 1986; Kiser, 1988; De Jong & Hopwood, 1996). However, such subjective and uncontrolled studies, whilst providing useful early indicators, do not have the necessary rigour to allow more conclusive statements about the effectiveness of the approach.

There are now increasing numbers of outcome studies being published, many of them using a similar design to those above and reporting varied levels of effectiveness. However, in a recent conference paper given in April, 1999, Wallace Gingerich, an early member of the Milwaukee group, and Sheri Eisengart reported on a more recent substantial rise in controlled studies (see the list below). They identified 15 such studies, 7 of which which assert that,

> SFBT (solution-focused brief therapy) equalled or surpassed the outcomes of standard treatment. SFBT sometimes produced better outcomes, and sometimes produced comparable outcomes in less time. Only one study (Littrell, et al., 1995) failed to report any positive outcomes for SFBT .... The fifteen studies included a wide range of modalities, ranging from the individual and family therapy, to group, consultative, supervisory and network interventions. Five of the six studies that employed individual or family therapy of two or more sessions duration, the modality most consistent with the original form of SFBT, had positive outcomes. However, studies that used indirect interventions such as consultation or supervision had a comparable success rate. Most of the studies used real-world clinical populations, and client problems ranged all the way from common mental health problems, to school functioning, self-sufficiency, delinquent behaviour, and work hardening. This represented an unexpectedly wide range of application of SFBT.
>
> We also find it interesting that in all but one of the studies (Lambert et al, 1998) the SFBT intervention appeared to be implemented by relatively inexperienced therapists, in many cases just newly trained. In psychotherapy research generally, experienced therapists tend to get better results than inexperienced therapists. (Gingerich & Eisengart, 1999)

However, Gingerich and Eisengart refer to the lack of proceduralization, of evidence of treatment integrity, and the fact that over half of investigators were advocates of SFBT, as important reasons for caution. They comment that, whilst " .. providing promising evidence ... None of the studies meet accepted standards for empirically validated treatments."

Nevertheless, as Gingerich and Eisengart point out,

> That 15 studies have appeared in so short a time is rather remarkable for an intervention approach that has been in existence for less that 20 years. It is all the more remarkable when one considers that SFBT evolved out of a clinical context, not a quantitative research context, and that all of the published studies were carried out by investigators outside the original Milwaukee group. (Gingerich & Eisengart, 1999)

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For Further Reading

Berg and Miller's *Working with the Problem Drinker: A Solution-Focused Approach* is an excellent description of the use of the model which has applicability far outside its focus. de Shazer's succession of books, *Keys to Solution in Brief Therapy*, *Clues: Investigating Solutions in Brief therapy*, *Putting Difference to Work*, and *Words Were Originally Magic* give a brilliant and highly readable insight into the development of the model over time, are full of practical ideas and examples, and are to be highly recommended. Walter and Peller's *Becoming Solution-Focused in Brief Therapy* is a clear and comprehensive guide to developing the approach. Miller, Hubble and Duncan's *Handbook of Solution-Focused Brief Therapy* is full of suggestions and brings together twenty eight experts from a range of settings who present research information, case examples and a host of practical techniques. The following web sites are also of particular relevance and will give links to other sites,

Brief Family Therapy Center, Milwaukee	www.brief-therapy.org
The Institute for the Study of Therapeutic Change	www.talkingcure.com
The European Brief Therapy Association	www.ebta.nu

The full reference for this chapter is:

Cade, B. (2001) Building alternative futures: The solution-focused approach. In S. Cullari (Ed) **Counselling and Psychotherapy**. Needham Heights, MA: Allyn and Bacon. (pp. 182-216)