

More Than Miracles

The State of the Art of Solution-Focused Brief Therapy

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Chapter 1

A Brief Overview

Solution-focused brief therapy (SFBT) is a future-focused, goal-directed approach to brief therapy developed initially by Insoo Kim Berg, Steve de Shazer, and their colleagues and clients at the Milwaukee Brief Family Therapy Center in the early 1980s. Developed inductively rather than deductively, SFBT is a highly disciplined, pragmatic approach rather than a theoretical one (Berg & Miller, 1992, Berg & Reuss, 1997; de Shazer, 1985, 1988, 1991, 1994). The developers observed hundreds of hours of therapy over the course of years, carefully noting the questions, behaviors, and emotions that led to clients conceptualizing and achieving viable, real-life solutions.

The questions that proved to be most consistently related to clients' reports of progress and solutions were carefully noted and painstakingly incorporated into the solution-focused approach, while those that did not were deliberately eliminated. Since then, the solution-focused brief therapy approach has become one of the leading schools of brief therapy throughout the world as well as a major influence in such divergent fields as business, social policy, and education.

MAJOR TENETS OF SFBT

SFBT is not theory based, but was pragmatically developed. One can clearly see the roots of SFBT in the early work of the Mental Research Institute in Palo Alto and of Milton H. Erickson; in Wittgensteinian philosophy; and in Buddhist thought. There are a number of tenets that serve as the guidelines for the practice of SFBT, and that both inform and characterize this approach.

If it isn't broken, don't fix it. This is the overarching tenet of SFBT. Theories, models, and philosophies of intervention are irrelevant if the client has already solved the problem. Nothing would seem more absurd than to intervene upon a situ-

ation that is already resolved. While this seems obvious, in reality there are some schools of psychotherapy that would encourage therapy in spite of improvement—for example, for “growth,” to “solidify gains,” or to get to “deeper meanings and structures.” SFBT is antithetical to these. If there is no problem, there should be no therapy.

If it works, do more of it. Similar to the first tenet, this tenet continues the “hands-off” approach. If a client is in the process of solving a problem, the therapist’s primary role should be to encourage the client to do more of what is already working. SFBT therapists do not judge the quality of a client’s solutions, only whether a solution is effective. Following this, another related role for the therapist is helping the client maintain desired changes. This is accomplished by learning exactly how the client behaved or responded differently during periods of improvement. As a result of identifying what worked, the client is able to repeat this success and the solution further evolves.

If it’s not working, do something different. To complete the obvious first three, this tenet suggests that no matter how good a solution might seem, if it does not work it is not a solution. An odd reality of human nature is the tendency to continue to try to solve problems by repeating the same things that have not worked in the past. This is especially true for psychotherapy, where many theories suggest that if the client does not improve (i.e., solve the problem), the fault rests with the client rather than the therapy or the theory. In SFBT, however, if a client does not complete a homework suggestion or experiment, the task is dropped, and something different is offered.

Small steps can lead to big changes. SFBT can be understood as a minimalist approach in which solution construction is typically accomplished in a series of small, manageable steps. It is assumed that once a small change has been made, it will lead to a series of further changes, which in turn lead to others, gradually resulting in a much larger systemic change without major disruption. Thus, small steps toward making things better help the client move gradually and gracefully forward to accomplish desired changes in their daily life and to subsequently be able to describe things as “better enough” for therapy to end.

The solution is not necessarily directly related to the problem. Whereas almost all other approaches to change have problem-leading-to-solution sequences, SFBT develops solutions by first eliciting a description of what will be different when the problem is resolved. The therapist and the client then work backward to accomplish this goal by carefully and thoroughly searching through the client’s real-life experiences to identify times when portions of the desired solution description already exist or could potentially exist in the future. This leads to a model of therapy that spends very little or even no time on the origins or nature of the problem, the client’s pathology, or analysis of dysfunctional interactions. While these factors may be interesting, and possibly could influence client behavior, SFBT focuses almost exclu-

sively on the present and future. Viewed in this way, SFBT involves a true paradigm shift from other models of psychotherapy.

The language for solution development is different from that needed to describe a problem. The language of problems tends to be very different from that of solutions. As Ludwig Wittgenstein put it, “The world of the happy is quite another than that of the unhappy” (T, #6.43). Usually problem talk is negative and past-history focused (to describe the origins of the problem), and often suggests the permanence of a problem. The language of solutions, however, is usually more positive, hopeful, and future-focused, and suggests the transience of problems.

No problems happen all the time; there are always exceptions that can be utilized. This tenet, following the notion of problem transience, reflects the major intervention that is used continuously in SFBT, that is, that people always display exceptions to their problems, even small ones, and these exceptions can be utilized to make small changes.

The future is both created and negotiable. This tenet offers a powerful basis for the practice of SFBT. People are not seen as locked into a set of behaviors based on a history, a social stratum, or a psychological diagnosis. With strong social constructionist support, this tenet suggests that the future is a hopeful place, where people are the architects of their own destiny.

SFBT has its roots in the systems theory-based family therapies of the 1950s and 1960s and the work of Milton H. Erickson (Haley, 1973). Both Insoo Berg and Steve de Shazer had strong connections to the Mental Research Institute of Palo Alto, California. While the researchers at MRI focused primarily on problem formation and problem resolution (Watzlawick, Weakland, & Fish, 1974), the Brief Family Therapy Center in Milwaukee began exploring solutions. For a number of reasons, the current SFBT approach can be seen as a systemic therapy. First, SFBT therapists routinely treat systems because couples and families—as well as individuals—come in for treatment. SFBT therapists make their decision on who to see in a session based on who shows up; whoever walks in the door is seen. Second, SFBT is systemic because the solutions that are explored are interactional, that is, people’s problems and their exceptions involve other people, very often family members, colleagues at work, or relationship partners and friends. Third, SFBT is systemic because once small changes begin to occur, larger changes often follow, and those larger changes are usually interactional and systemic.

THE ROLE OF THE THERAPIST

The role of the therapist in SFBT is different than in many other psychotherapeutic approaches. SFBT therapists accept that there is a hierarchy in the therapeutic arrangement, but this hierarchy tends to be more egalitarian and democratic than au-

thoritarian. SFBT therapists almost never pass judgments about their clients, and avoid making any interpretations about the meanings behind their wants, needs, or behaviors. The therapist's role is viewed as trying to expand rather than limit options (Berg & Dolan, 2001). SFBT therapists lead the session, but they do so in a gentle way, "leading from one step behind" (Cantwell & Holmes, 1994, pp. 17-26). Instead of interpreting, cajoling, admonishing, or pushing, the therapist "taps on the shoulder" of the client (Berg & Dolan, 2001, p. 3), pointing out a different direction to consider.

THERAPEUTIC PRINCIPLES AND TECHNIQUES

Main Interventions

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

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

Looking for exceptions. Even when clients do not have a previous solution that can be repeated, most have recent examples of exceptions to their problem. An exception is thought of as a time when a problem could occur, but does not. The difference between a previous solution and an exception is small but significant. A previous solution is something that the family has tried on their own that has worked, but for some reason they have not continued this successful solution, and probably forgot about it. An exception is something that happens instead of the problem, usually without the client's intention or maybe even understanding.

Questions vs. directives or interpretations. Questions, of course, are an important communication element of all models of therapy. Therapists use questions often with all approaches, especially while taking a history, checking in at the beginning of a session, or finding out how a homework assignment went. SFBT therapists, however, make questions the *primary* communication tool, and as such they are an

overarching intervention. SFBT therapists tend to make no interpretations, and rarely make direct challenges or confrontations to a client.

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

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

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

Specific Interventions

Pre-session change. At the beginning or early in the first therapy session, SFBT therapists typically ask "What changes have you noticed that have happened or started to happen since you called to make the appointment for this session?" This question has three possible answers. First, the client may say that nothing has happened. In this case, the therapist simply goes on and begins the session by asking something like: "How can I be helpful to you today," or "What would need to happen today to make this a really useful session?"

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

The third possible answer is that things are about the same. The therapist could ask something like: "Is this unusual, that things have not gotten worse?" or "How have you all managed to keep things from getting worse?" These questions may lead

to information about previous solutions and exceptions, and may move them into a solution-talk mode.

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

Miracle question. Some clients have difficulty articulating any goal at all, much less a solution-focused goal. This is particularly true for multiproblem families, or clients for whom the problem is so severe, they feel that even the description of a goal somehow minimizes the magnitude of the problem and how overwhelming it feels. The miracle question is a way to ask for a client's goal that communicates respect for the immensity of the problem, yet at the same time leads to the client coming up with smaller, more manageable goals.

The precise language of the intervention may vary, but the basic wording is:

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

Clients have a number of reactions to the question. They may seem puzzled. They may say they don't understand. They may smile. Usually, however, given enough time to ponder it, they come up with some very specific things that would be different when their problem is solved. The responses they give can then usually be taken as the goals of therapy. As such, their answers lead to a more detailed description of how they would like their life to be, which in turn can help elucidate their previous solutions and exceptions.

In therapy with couples, families, or work groups, the miracle question can be asked to individuals or to the group as a whole. If asked to individual members, each one would give his or her response to the question, and others might react to it. The

therapist would try to elicit support for each member's miracle. If the question is asked to the couple, family, or work group as a whole, members may "work on" their miracle together. The SFBT therapist, in trying to maintain a collaborative stance among family members, punctuates similar goals and supportive statements among family members. (See subsequent chapters for more details about the "miracle question" and its use.)

Scaling questions. Whether the client gives specific goals directly or via the miracle question, an important next intervention in SFBT is to scale each goal. The therapist asks the miracle question's scale: From 0-10 or from 1-10, where things were when the initial appointment was arranged, where things are now, and where they will be on the day after the miracle, i.e., when therapy is "successful." For example, with a couple for whom better communication is the goal:

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

HUSBAND: That is pretty unrealistic.

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

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

HUSBAND: Yeah, I'd say a 2.

THERAPIST: Okay [*writing*] . . . a 2-3 for you, and a 2 for you. Now, tell me what you would be satisfied with when therapy is over and successful?

WIFE: I'd be happy with an 8.

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

THERAPIST: What would you say it is right now?

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

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

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

There are two major components of this intervention. First, it is a solution-focused assessment device, that is, if used at each session, the therapist and the clients have an ongoing measurement of their progress. Second, it is a powerful intervention in and of itself, because it allows the therapist to focus on previous solutions

and exceptions, and to punctuate new changes as they occur. As with the changes made before the first session, there are three things that can happen between each session: (1) things can get better; (2) things can stay the same; (3) things can get worse.

If the scale goes up, and things get better from one session to the next, the therapist compliments the clients, then solicits extensive details describing how the clients were able to make such changes. This not only supports and solidifies the changes, but leads to the obvious nudge to "do more of the same." If things "stay the same," again, the clients can be complimented for maintaining their changes, or for not letting things get worse. "How did you keep it from going down?" the therapist might ask. It is interesting how often this question will lead to a description of changes the clients have made, in which case again the therapist can compliment and support and encourage more of that change.

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

WIFE: [Pauses.] I'd say a 5.

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

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

THERAPIST: How did you communicate better this week?

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

THERAPIST: That's great. Can you give me an example of when he listened to you more?

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

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

WIFE: Yes.

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

WIFE: He has always done that.

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

WIFE: Yes, for sure.

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

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

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

WIFE: Yes.

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

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

THERAPIST: That's great. What else have you done to try to make the communication better this week?

This example shows how going over the scale with the couple served as a vehicle for finding the clients' progress. The therapist gathered more and more information about the small changes the clients had made on their own, that led to an improvement on the scale. This would naturally lead to the therapist suggesting that the couple continue to do the things that are working, in this case for the husband to continue calling her, and continue to engage in the active listening that she found so helpful. (See subsequent chapters for more details about "scaling questions.")

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

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

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

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

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

DAUGHTER: I did that a lot; last semester I did.

THERAPIST: Can you give me an example of the last time you did that?

MOTHER: I can tell you, it was last week, actually. She was all excited about her science project getting chosen.

THERAPIST: Tell me more, what day was that . . . ?

MOTHER: I think last Wednesday.

THERAPIST: And she came home . . .

MOTHER: She came home all excited.

THERAPIST: What were you doing?

MOTHER: I think the usual, I was getting dinner ready. And she came in all excited, and I asked her what was up, and she told me her science project was chosen for the display at school.

THERAPIST: Wow, that is quite an honor.

MOTHER: It is.

THERAPIST: So then what happened?

MOTHER: Well, we talked about it; she told me all about it.

THERAPIST: Anita, do you remember this?

DAUGHTER: Sure, it was only last week. I was pretty happy.

THERAPIST: And would you say that this was a nice talk, a nice talk between you two?

DAUGHTER: Sure. That's what I mean; I don't always go in my room.

THERAPIST: Was there anything different about that time, last week, that made it easier to talk to each other?

MOTHER: Well, she was excited.

DAUGHTER: My mom listened, wasn't doing anything else.

THERAPIST: Wow, this is a great example, thank you. Let me ask this, if it were like that more often, where Anita talked to you about things that were interesting and important to her, and where Mom, you listened to her completely without doing other things, is that what you two mean by better communication?

DAUGHTER: Yeah, exactly.

MOTHER: Yes.

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

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

Is there anything I forgot to ask? Before taking a break and reconvening or alternatively, sometime during the session, the therapist asks the client, "Is there anything I forgot to ask?" or "Is there something else I need to know?"

Taking a break and reconvening. Many models of family therapy have encouraged therapists to take a break toward the end of the session. Usually this involves a conversation between the therapist and a team of colleagues or a supervision team

who have been watching the session and who give feedback and suggestions to the therapist. In SFBT, therapists are also encouraged to take a break near the session end. If there is a team, they give the therapist feedback, a list of compliments for the family, and some suggestions for interventions based on the clients' strengths, previous solutions, or exceptions. If there is not a team available, the therapist will still take a break to collect his or her thoughts, and then come up with compliments and ideas for possible experiments. When the therapist returns to the session, he or she can offer the family compliments.

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

DAUGHTER: [*Seeming pleased.*] Wow, thanks!

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

cess that people use to move slowly and cautiously into change rather than as evidence of psychopathology), certainly when clients initiate their own homework, there is a greater likelihood of success.

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

DAUGHTER: Maybe that we talk more?

THERAPIST: Can you tell me more?

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

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

MOTHER: Yeah, that's good.

THERAPIST: So let's make this clear. Anita will try to talk to you more when she comes home from school. And you will put down what you are doing, if you can, and listen and talk to her about what she is talking to you about. Anything else? Anything you want to add?

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

THERAPIST: Well, that sure seemed to work for you two last week. Okay, so that's the assignment. We'll see how it went next time.

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

So, what is better, even a little bit, since the last time we met? At the start of each session after the first one the therapist will usually ask about progress, about what has been better during the interval. Many clients will report that there have been some noticeable improvements. The therapist will help the client describe these changes in as much detail as possible. Of course some clients will report that things have remained the same or have become worse. This will lead the therapist to explore how the client has managed to keep things from becoming worse, or, if worse, what the client did to prevent things from becoming *much* worse. Whatever the client has done to prevent things from worsening is then the focus and a source for com-

pliments and perhaps for an experiment, because whatever they did they should continue doing. During the session, usually after there has been a lot of talk about what is better, the therapist will ask the client to rate himself or herself on the progress (toward solution) scale. Of course when the rating is higher than the previous session's, the therapist will compliment this progress and help the client figure out how to maintain the improvement.

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

One difference between SFBT and other homework-driven models, such as cognitive-behavioral therapy, is that the homework itself is not required for change per se, so not completing an assignment is not addressed. If the client does not complete an assignment it is assumed that: (a) something realistic got in the way of its completion, such as work or illness; (b) the client did not find the assignment useful; (c) the assignment was not relevant during the interval between sessions. In any case, there is no fault assigned. If the client did the assignment but things did not improve or became worse, the therapist handles this in the same way he or she would when problems stay the same or become worse in general.

TREATMENT APPLICABILITY

Solution-focused therapy is one of the most popular and widely used models of therapy in the world. Because it is based on the concept of resiliency, and on clients' own previous solutions and exceptions to their own problems, it is applicable to all problems, and indeed has been applied to a wide range of problems seen by clinicians. These include family therapy (McCullum & Trepper, 2001); couples therapy (Weiner-Davis, 1993); treatment of sexual abuse (Dolan, 1991); treatment of substance abuse (Berg & Miller, 1992; de Shazer & Isebaert, 2003); and treatment of schizophrenia (Eakes, Walsh, Markowski, Cain, & Swanson, 1997). There have been self-help books written from a solution-focused perspective (Dolan, 1998), and the solution-focused approach has been applied beyond traditional psychotherapy practice to include interventions in social service agencies (Pichot & Dolan, 2003), educational settings and model schools (Rhodes & Ajmal, 2001), and business systems (Caufman, 2001).

**RESEARCH ON THE EFFECTIVENESS
OF SOLUTION-FOCUSED BRIEF THERAPY**

Considering the wide use of SFBT, both in clinical practice and in other social systems, it is unfortunate that more empirical research has not been done on its effectiveness. In the most thorough review to date, Gingerich and Eisengart (2000) review 15 empirical studies on SFBT effectiveness. Of the five studies that were considered well-controlled, four were found to be superior to no treatment or treatment as usual; the fifth was found to be equal to a known intervention, interpersonal psychotherapy for depression. The findings for the remaining ten studies, which were not considered as well-controlled or which had methodological problems, all support SFBT's effectiveness. Gingerich and Eisengart conclude that, while this review provides preliminary support for SFBT's effectiveness, more and better-controlled studies are necessary.

SUMMARY

SFBT is a paradigm shift from the traditional psychotherapy focus on problem formation and problem resolution that underlies almost all psychotherapy approaches since Freud. Instead, SFBT draws upon clients' strengths and resiliencies by focusing on their own previous or conceptualized solutions and exceptions to their problems, and then, through a series of interventions, encouraging the clients to do more of those behaviors. SFBT can be applied to a myriad of family-related problems. SFBT, while deceptively easy to learn, like all therapies, requires great skill to reach a level of proficiency. While the preliminary research on the effectiveness of SFBT has been positive, clearly more research, especially clinical trial studies, are needed.



THE MIRACLE QUESTION

Steve de Shazer
(BFTC)

The miracle question was developed beginning in the early 80s and I have been using it in almost every first session ever since.

I think my (our) initial mistake was to call it "**the miracle question**" when it has never been just a simple question. Rather, its purpose was to shift the conversation quickly and easily into the future when the problems (that brought the client to therapy) were gone. That is to say, the "question" itself was never as important as the client's response. Over the years of dealing with the wide variety of client responses I have somehow sort of learned how best to respond to their responses. In part, I learned this from watching how Insoo Kim Berg responds to her clients' responses. Further, I learned this from watching how other therapists' responsive behaviour did not lead to the kind of miracle picture Insoo's clients were able to develop. So here is a sketch of the pattern that I have worked out.

PART ONE

"I have a strange, perhaps unusual question, a question that takes some imagination ...

[Pause. Wait for some sort of signal to go ahead with the question.]

Suppose . . .

[Pause. The pause allows clients to wonder what strange and difficult thing I might ask them to suppose.]

After we finish here, you go home tonight, watch TV, do your usual chores, etc., and then go to bed and to sleep . . .

[Pause. Pretty normal, everyday stuff. Not so strange after all.]

And, while you are sleeping, a miracle happens . . .

[Pause. The context for this miracle is the client's normal, everyday life. This construction allows for any kind of fantastic wishing.]

And, the problems that brought you here are solved, just like that! . . .

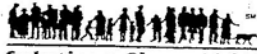
[Pause. Now the focus is on one particular miracle that is in line with his or her coming to therapy.]

But, this happens while you are sleeping, so you cannot know that it has happened."

[Pause. This is designed to allow the client to construct his or her miracle without any consideration of the problem and without any consideration of the steps that be or might have been involved.]

"Once you wake up in the morning, a) how will you go about discovering that this miracle has happened to you?" OR, b) "how will your best friend know that this miracle happened to you?"

[Wait. The therapist should not interrupt this silence; it is the client's turn to talk, to answer the question. In fact, when the client's response is "un-reasonable" (in the therapist's view) the



therapist's most useful response is to continue his/her silence which gives the client a change to "fix" the response, to make it more reasonable.]

[Many clients, particularly adolescents, find it easier to describe the day-after-the-miracle from the perspective of other people. The individual's perspective is then dealt with in Part Two.]

PART TWO

"A) How will your best friend discover that this miracle happened to you?"

OR,

B) "how will you discover that this miracle has happened to you?"

PART THREE

"When was the most recent time (perhaps days, hours, weeks) that you can remember when things were sort of like this day after the miracle?"

PART FOUR

"On a scale from 0 to 10, with 10 standing for how things are the day after the miracle and 0 standing for how things were at the point you called to arrange this appointment, where - between 0 and 10 - are you at this point?"

[This "progress scale" is designed to help both therapist and client figure out where the client is in relation to his/her goal(s) for therapy.]

"On the same scale, where do you think your best friend would say you are?"

"On the same scale, where would you say things were when things were sort of like this miracle day?"

PART FIVE

(The opening question in second and later sessions.)

"So, what is better?"

["Better" is a construction and this is designed to remind both therapist and client that one of the goals in these subsequent sessions is to help the client describe things as "better." Failure to begin the subsequent sessions with this question undermines the value of the other four parts.]

PART SIX

(The "progress scale.")

"Remember that scale where 10 stands for the day after the miracle? Where would you say you are today on that scale?"

[It seems more useful to ask about this without reminding the client of his/her previous rating. If the question is asked this way: "Last time you were at 3, where are you now?" Clients tend to respond with "3" and they tend to respond to the open version with a rating "higher" than that they gave in the previous session.]

The Solution-focused Therapy Model: the First Session

Introduction: Key Questions

Introduce yourself.

What do you like to be called?

What do you want to get out of being here today?

Problem: Key Questions

How often does this... happen? (days/parts of days)

How long has it been going on?

Has it ever happened before?

How did you deal with it?

It is important to get a practical description in behavioral terms:

Examples

What is said/done?

Who says it/does it?

Who notices?

What happens next? And then what?

What else?

(If the description is unclear you may ask "If you made a video of...happening what would I see?")

Pre-session Changes: Key Questions

Have there been changes for better or worse since you decided to take action?

Who else noticed this?

Goals: Key Questions

What will it be like when the problem is solved?

What will you be doing instead?

When that happens, what difference will it make?

How will other people know that things are better?

Who will notice first? And then who?

What else will be different?

What else?

What else?

(It is important to ask what they will be doing, not what will have stopped.)

Exceptions: Key Questions

What about times when the problem is not happening?

Or when it is less?

You mentioned earlier that some days/times are better. What is it like at these times?

What are you doing instead at these times?

What else is better at these times?

Who notices first when things are better for you?

And then who?

What do they notice at these times?

What else?

(Again, as with goals, it is important to get descriptions of what they are doing, not of what they are not doing.)

Scaling: Key Questions

Please think of a scale from 0–10 with 10 being the best. Not is how you felt when things were at their worst. Ten is as good as things can be in relation to this problem.

Where are you now on that scale right now? [pause] Give it a number, for example 2 or 3. If not precise, ‘nearer 2 or nearer 3’?

How long will it take to get to 10? [prompt if necessary to get a time – 5 years? More? Less?]

Maybe 10 is too big a goal?

Is something lower more realistic?

What number will be acceptable for you?

How will you recognize when you are one point further up the scale?

What else will be different when you are one point further up?

Who will notice?

How long will it take to get one point up the scale?

(Clients sometimes need some prompts to answer ‘How long ...?’)

Miracle Question

I’m going to ask you a kind of strange question now.

Suppose [pause] you go to sleep tonight as usual [pause]

and while you are asleep a miracle happens [pause] and because you are asleep you do not know that the miracle has happened. When you awake in

the morning what will be different that will tell you that the miracle has taken place? What else? (Or can ask ... But you are asleep and don't know that it has been solved [pause].What will be the first small signs that this miracle has happened and that the problem is solved?)

Surviving the Present: Key Questions

How will you get through the rest of today?

How have you kept going so far?

What else helps?

Is there anyone else who shares this with you?

What were the happiest times with X?

Can you do any of the same things without X?

What can you do keep their memory alive?

What would X want for you now?

What is happening now that you want to go on happening?

Key Points

- Language matching is a major strength of solution-focused therapy.
- The sequence of questions may vary once the therapist feels confident about this.
- Maintaining the flow of the interview is important.
- Concrete and behavioral descriptions of events clarify the situation and make it appear more manageable.
- Talking about the problem is a means of joining with the client.
- Pre-session changes are important building blocks for progress.

- Goals are central to monitoring progress.
- Exceptions are common but often go unnoticed.
- Scales can be used in many different ways.
- The miracle question encourages creative thinking and some surprising changes

follow its use.

Solution-Focused Family Therapy Resources

1. <http://www.basic-counseling-skills.com/solution-focused.html>- a brief article
3. Videos-<http://www.youtube.com/watch?v=l-Tu1TZ6Kc0> a shorter video
5. <http://www.youtube.com/watch?v=rXhJUvBL7oc-> 20 solution focused techniques
6. YouTube- Solution-Focused Couples Therapy with Kim Insoo-Berg (in syllabus is the whole session) <http://www.youtube.com/watch?v=fQBZlgmewY>
7. <http://www.youtube.com/watch?v=8zuyT9Uw63Y> Discusses Family
8. http://www.sagepub.com/upm-data/41972_9780857028907.pdf chapter
9. <http://www.solutionfocused.net/solutionfocusedtherapy.html>
10. <http://ctiv.alexanderstreet.com.mutex.gmu.edu/view/1778954> one and a half hours. Go look at it, scan the side bar verbatim comments and focus on the parts that seem relevant to you.