Solution Focused Therapy
Treatment Manual for Working with Individuals
2nd Version*©

Solution Focused Brief Therapy Association
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* This document will continually be revised to reflect updates in clinical practice and research relevant to SFBT.

OVERVIEW, DESCRIPTION, AND RATIONALE

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

Solution-Focused Brief Therapy is based on over twenty-five years of theoretical development, clinical practice, and empirical research (e.g., de Shazer et al.,1986; Berg & Miller, 1992; Berg, 1994; De Jong & Berg, 2008; de Shazer, et al., 2007). Solution-Focused Brief Therapy is different in many ways from traditional approaches to treatment. It is a competency-based and resource-based model, which minimizes emphasis on past failings and problems, and instead focuses on clients' strengths, and previous and future successes. There is a focus on working from the client's understanding of her/his concern/situation and what the client might want different. The basic tenets that inform Solution-Focused Brief Therapy are as follows:

- It is based on solution-building rather than problem-solving.
- The therapeutic focus should be on the client's desired future rather than on past problems or current conflicts.
- Clients are encouraged to increase the frequency of current useful behaviors.
- No problem happens all the time. There are exceptions—that is, times when the problem could have happened but didn't—that can be used by the client and therapist to co-construct solutions.
- Therapists help clients find alternatives to current undesired patterns of behavior, cognition, and interaction that are within the clients' repertoire or can be co-constructed by therapists and clients as such.
- Differing from skill building and behavior therapy interventions, the model assumes that solution behaviors already exist for clients.
- It is asserted that small increments of change lead to large increments of change.
- Clients' solutions are not necessarily *directly* related to any identified problem by either the client or the therapist.
- The conversational skills required of the therapist to invite the client to build solutions are different from those needed to diagnose and treat client problems.

EVIDENCE BASE OF SOLUTION-FOCUSED BRIEF THERAPY

SFBT has been recognized as an evidence-based practice and appears on the Substance Abuse Mental Health Services Administration's National Registry of Evidence-Based Programs and Practices (http://www.nrepp.samhsa.gov) and the Office of Juvenile Justice and Delinquency Prevention Model Programs Guide (http://www.ojjdp.gov/mpg/). There is also a growing body of outcome studies using more rigorous experimental designs that demonstrate the effectiveness of SFBT (Franklin, Trepper, Gingerich, & McCollum, 2012). Within quantitative research, a meta-analysis study of a particular intervention is viewed as the strongest evidence supporting the intervention's effectiveness followed by experimental design studies (Fraser, Richman, Galinsky, & Day, 2009). Two independent meta-analyses of SFBT have been conducted, one by a team of Dutch researchers (Stams, Dekovic, Buist, & De Vries, 2006) and one by a United States social work academic researcher (Kim, 2008). The Stams et al. (2006) meta-analysis involved 21 studies involving 1,421 participants and found an overall effect size estimate of 0.37, which is considered small to near medium treatment effect favoring SFBT. The second meta-analysis by Kim (2008) analyzed treatment effects of SFBT for externalizing behavior, internalizing behavior, and family or relationship problems. Overall 22 studies were included in Kim's meta-analysis with effect size estimates ranging in the small range (0.13-0.26) for all three outcomes. Results from these systematic reviews, along with other experimental design studies noted in Appendix A, show SFBT to have small to medium positive treatment effects. In addition to the meta-analysis completed by (Stams, et.al. 2006 & Kim, 2008)], Gingerich & Peterson (2013) conducted a qualitative review of 43 controlled outcome studies on SFBT and concluded that SFBT is an effective approach with many different psychosocial conditions with children/adolescents and adults. Evidence from the studies reviewed further indicated that SFBT is especially efficacious for adults with depression. See Appendix A for a table of outcome studies on SFBT.

In addition to outcome studies (randomized controlled trials) that support the effectiveness of SFBT practice (e.g., Kim, Smock, Trepper, McCollum, & Franklin, 2010), there is both theoretical and empirical support for SFBT process. The theory of co-construction that is basic to the SFBT therapeutic process comes from a theoretical tradition that spans several disciplines including sociology, psychology and communication studies (e.g., Berger & Luckmann, 1966; de Shazer, 1994; Gergen, 2009; McNamee & Gergen, 1992). The use of language and the co-construction process are integral to the SFBT change process and will be described in more detail below. The empirical details of the SFBT approach to language use in dialogue have a solid experimental basis in contemporary psycholinguistic research (e.g., review in Bavelas, 2012). Finally, there is recent and ongoing original research on the specific dialogic processes by which co-construction happens both in SFBT versus in contrasting therapies (e.g., Phillips 1998, 1999; McGee 1999; McGee, Del Vento, & Bavelas, 2005; Tomori, 2004; Tomori & Bavelas, 2007; Korman, Bavelas, & De Jong, in press; Smock Jordan, Froerer, & Bavelas, in press; Froerer & Smock Jordan, in press). Additionally, there is additional change process research that shows that the therapeutic

techniques used in SFBT may have positive affects on client change. For example, therapeutic processes such as pre-suppositional questions, "solution talk," and engendering hope and positive expectations in clients toward change increased positive results in client goals. Techniques such as the scaling question and miracle question have also been shown to accomplish their intended purposes in therapy sessions (McKeel, 2012). See Appendix B for a review of the research that shows how Co-Construction works in SFBT process.

SOLUTION-FOCUSED THERAPEUTIC PROCESS

Psychotherapeutic process is defined as

> Whatever occurs between and within the client and psychotherapist during the course of psychotherapy. This includes the experiences, attitudes, emotions, and behavior of both client and therapist, as well as the dynamic, or interaction, between them (Vandebos, 2007, p. 757).

The SFBT approach to the therapeutic process is unique in at least three ways. First, other approaches to process focus primarily on what happens within the client. For example, when defining "mechanisms of change" in psychotherapy, Nock (2007, p. 8S) included only psychological or biological processes and explicitly excluded the communication between the therapist and client. SFBT equates therapeutic process with the *therapeutic dialogue,* that is, what happens between therapist and client (e.g., McKergow & Korman, 2009). The change process in SFBT is *the therapist's and client's co-construction of what is important to the client: his or her goals, related successes, and resources.* SFBT training and practice focuses on the details of how this conversational process occurs by attending to the therapist's and client's moment-by-moment exchanges (e.g., De Jong & Berg, 2013; de Shazer et al., 2007).

Second, the SFBT approach to dialogue as the essential therapeutic process focuses on what is *observable* in communication, and social interactions between client and therapist. As will be illustrated below, the specific exchanges through which a process known as, co-construction, happens are observable, whereas global inferences or characterizations of therapeutic communication or relationships are not. Thus, the SFBT process consists of what the therapist says and does rather than on his or her intentions. This commitment to systematic observation as the basis of what is and is not useful in SFBT dates back to its origins at the Brief Family Therapy Center (BFTC) in Milwaukee, founded by de Shazer, Berg, and colleagues. The earliest research at BFTC was exploratory and qualitative, involving intense observation of therapy sessions through a one-way mirror by a team of experienced practitioners, clinical professors, and graduate students as well as subsequent reviewing of the video-recordings. They looked for when clients made progress (as the clients defined progress) and they examined what the practitioners might be doing that was contributing to that progress. Through open and lively discussion over several years, the team invented and experimented with several new techniques that eventually became fundamental parts of SFBT, including questions about pre-session change, exceptions, the miracle question,

as well as the formula tasks (de Shazer 1985, p. 119-136). As each technique became part of SFBT practice, further observation and process research documented its usefulness. This way of observing, inventing something new, and gathering data to test the usefulness of specific practices is described in several sources (Adams, Piercy, & Jurich, 1991; De Jong & Berg, 2013; Lipchik, Derks, LaCourt, & Nunnally, 2012; Weiner-Davis, de Shazer, & Gingerich, 1987, Miller, 2004).

Third, SFBT was developed using an empirical basis in language use in dialogue that has a solid experimental basis in contemporary psycholinguistic research (e.g., review in Bavelas, 2012). Thus, the evidence-base of SFBT started on a firm foundation in basic research and the theoretical developments were further transported to work in a family therapy clinic where these communication processes were further refined in the processes of brief psychotherapy.

SFBT PROCESS AS LISTEN, SELECT, BUILD

In SFBT, therapists and clients engage in a process of co-construction that results in clients' talking about themselves and their situations in new and different ways. Co-construction is a collaborative process in communication where speaker and listener collaborate to produce information together, and this jointly produced information in turn acts to shift meanings and social interactions. The principles of this conversational process between therapist and client are the same regardless of the concern that each client brings to therapy. The conversation always focuses on what clients want to be different in their present and future and how to go about making that happen. SFBT is not an approach that has a long assessment phase that is meant to diagnose clients. In contrast, from the very beginning of therapy SFBT therapists use a language of change that facilitates goal setting and client centered solutions to problems. The signature questions and responses by therapists in solution-focused interviews are intended to initiate a co-constructive process which De Jong and Berg (2013), following the lead of de Shazer (1991; 1994; de Shazer et al., 2007), called *listen, select, and build*.

In this process, the SFBT therapist listens for and selects out the words and phrases from the client's language that are indications (initially, often only small hints) of some aspect of a solution, such as articulating what is important to the client, what he or she might want, related successes (e.g. exceptions), or client skills and resources. Once having made the selection, the therapist then composes a next question or other response (e.g., a paraphrase or summary) that connects to the language used by the client and invites the client to build toward a clearer and more detailed version of some aspect of a solution. As the client responds from his or her own frame of reference, the therapist continues to listen, select, and compose the next solution-focused question or response, one that is built on what the client has said. It is through this continuing process of listening, selecting, and building on the client's language that therapists and clients together co-construct new meanings and new possibilities for solutions. SFBT therapists also work hard not to make assumptions about any supposed "real or underlying meaning" of what clients are saying. Instead of reading between the lines,

SFBT therapists discipline themselves to listen for and work within the client's language by staying close to and using the words used by the client

An Example of SFBT Therapeutic Process

The practice of *listen, select, and build* is illustrated in the following dialogue between a solution-focused therapist (Harry Korman) and a young mother going through a difficult divorce and starting a new life with her 19-month-old son (De Jong, Bavelas, & Korman, in press). This excerpt occurred early in the session (right after introductions) and began the co-construction of what the client might want from meeting with the therapist.

1.	Korman	**So, umm. Is it okay if we start like, uh** [Pause]. **What will have to happen, as a result of you** [gestures toward her] **coming here today – this afternoon, tomorrow, the day after tomorrow – for you to feel that it's been somewhat useful to, to be here?**
2.	Client	**Um**.
3.	Korman	[Remains silent and settles into a listening posture, one hand holding his chin, looking directly at client.]
4.	Client	**I don't think I'm--** [laughs, then gestures toward therapist with a slight shrug
5.	Korman	[nods] **It's a difficult question.** [gestures and returns to a listening posture]
6.	Client	[overlapping] **--am even looking that far ahead**. [looks down] **Um.** [long pause]
7.	Korman	[stays in listening posture, remains silent]
8.	Client	**Maybe just** [pause] **to sort together everything I'm—**
9.	Korman	[overlapping: tilts head to the right as if more interested, then poises pen to write]
10.	Client	**--I'm feeling. I don't exactly know what that is yet.**
11.	Korman	[overlapping: nodding slowly, looks down and writes briefly and then looks back up at client keeping pen on pad]
12.	Client	**I don't…**[gestures with left hand towards the therapist]
13.	Korman	[overlapping: nods]
14.	Client	**I don't exactly know what's bothering me, like– I mean I—**
15.	Korman	[overlapping: nods continuously]
16.	Client	**I'm in the process of going through a divorce, so—**
17.	Korman	[Overlapping: Looks down to paper and writes briefly. Slightly overlapping with client finishing: makes a vigorous nod]
18.	Client	**I'm sure that's** [gestures toward him with both hands and then puts them on lap] **the majority of it.**
19.	Korman	[Overlap starting as she puts down her hands (this makes a small sound): looks up at her, then] **Mm, Mm.** [while nodding]

20.	Client	**I just recently haven't been able to sleep too well, 'n**—[pause]
21.	Korman	[Overlapping: looks down, writes and nods]
22.	Client	**So I thought maybe this might—[**pause] **help me sort out—whatever I need to—"** [while speaking, gestures between herself and him]
23.	Korman	[Overlapping: looks up at her as she says "might", then down to his notes. Nods and says:] **Right.**
24.	Client	**--to get my life** [slight pause] **back together**. [smile and slight laugh]
25.	Korman	[Looking down and writing as he talks:] **Help you sort something out to get your life together.** [Then nods and looks up at her; slight pause; then asks, while gesturing frequently toward her:] **So what would be a feeling, ah, a thought, an action, something you would do or think or feel that would tell you that you were sort of getting your life together** [keeps looking at her]
26.	Client	**Umm—**[pause]
27.	Korman	**--this afternoon or tomorrow?** [then looks down and places pen as if to start writing; looks up and tilts his head as soon as she starts to speak]
28.	Client	**I guess like—just, relaxing maybe** [gestures toward him].
29.	Korman	(with big nod, looking down and writing:] **Relaxing.**

The therapist began at #1 by asking a question about what the client might want by "coming here today." Instead of answering immediately, the client responded at #2 with "Um." This sort of pause and minimal response by the client to the question posed at #1 is common in SFBT interviews (because of the unusual questions), as is the SFBT therapist's response at #3. Rather than saying something, the therapist settled into a listening posture and looked directly at the client, waiting for her to say more about some aspect of a solution (e.g., what she wants, her resources or competencies). At this point, he was listening for her initial construction of what she might want from meeting with a therapist. At #4, the client again did not offer a direct answer, instead saying, with a shrug, "I don't think I'm --." At #5, the therapist acknowledged that he had asked a "difficult question" and resumed his listening posture. At #6, the client overlapped and finished her answer with "--am even looking that far ahead." This answer, which referred to the future, showed that she had understood his initial question about what she would like to see happen in the future, so he once again settled down to wait for more. At #8, #10, #12, #14, #16, #18, #20, and #22 the client offered a bit-by-bit construction of what she might want to come out of their meeting together. As she was doing this, the therapist said little but regularly displayed his interest and understanding of her words by communicative behaviors such as tilting his head to one side, poising his pen as if to write, looking down and writing briefly, looking back up at her, and nodding. At #17 and #21, he offered minimal verbal expressions, "Mm, Mm" and "Right."

It was not until #23 that he said anything beyond a minimal verbal response. The therapist's words at #23 are a clear example of the selecting and building that defines SFBT. First, he selected "help you sort something out to get your life together." By selecting these words from among everything she had said, the therapist implied that these particular words were the important part of her answer to his original question at #1. His selection also meant that he chose to ignore that she was "not looking that far ahead," that she did "not know what is bothering (her)," that she was "going through a divorce," that she was sure that the divorce was "the majority of it," and that she "recently [hasn't] been able to sleep too well."

At #23, the therapist started the building process by incorporating the client's initial construction of what she wanted ("to get my life back together") into his next question, "So what would be a feeling, ah, a thought, an action, something you would do or think or feel that would tell you that you were sort of *getting your life together*—this afternoon or tomorrow?" His choice of words not only connected closely to what she had said in #20 and #22, it also built in a new direction by asking for more concrete details that would indicate to her that she was "getting her life together." At #26, the client answered with one detail: "I guess like—just, relaxing maybe." At #27, the therapist again made a typical solution-focused selection by repeating only "Relaxing," emphasizing a possibly important indicator of "getting her life together." He chose to ignore other words ("I guess," "maybe") that indicated a lack of certainty. The therapist could now continue to build by asking another question that connected to "relaxing."

GENERAL INGREDIENTS OF SOLUTION FOCUSED BRIEF THERAPY

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

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

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

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

GOAL SETTING AND SUBSEQUENT THERAPY

The setting of specific, concrete, and realistic goals is an important component of SFBT. Goals[1] are formulated and amplified through SF conversation about what clients want different in the future. Consequently, in SFBT, clients set the goals. Useful goals in SFBT are: (1) salient and personally meaningful, (2) state positively what the clients will be doing instead of what they won't be doing, (3) stated in behavioral terms and as the first small step, (4) goals as within client's control, (5) goals as something new and different, and (6) goal as a behavior that the client can practice regularly (Lee, Sebold, & Uken, 2003; Lee, Uken, & Sebold, 2007). Once a beginning formulation is in place, therapy focuses on exceptions related to goals, regularly scaling how close clients are to their goals or a solution, and co-constructing useful next steps to reaching their preferred futures.

HOW SFBT IS CONTRASTED WITH OTHER TREATMENTS

SFBT is most similar to competency-based, resiliency-oriented models, such as some of the components of motivational enhancement interviewing (Miller & Rollnick, 2002; Miller, Zweben, DiClemente, & Rychtarik, 1994)**,** the strengths perspective and positive psychology**.** There are also some similarities between SFBT and cognitive-behavioral therapy, although the latter model has the therapist assigning changes and tasks while SFBT therapists encourage clients to do more of their own previous exception behavior and/or test behaviors that are part of the client's description of their goal. SFBT's focus on behavior, description and social context also show similarities to third wave behavioral therapies but SFBT does not exclusively rely on the same theories and change techniques as a part of its change processes. SFBT also has some similarities to Narrative Therapy (e.g., Freedman & Combs, 1996) in that both take a non-pathology stance, are client-focused, and work to create new realities as part of the approach. SFBT is most dissimilar in terms of underlying philosophy and assumptions with any approach which requires "working through" or intensive focus on a problem to resolve it, or any approach which is primarily focused on the past rather than the present or future.

Another feature that distinguishes SFBT from other treatment models is its view on assessment. Contrary to models of treatment that view professionals as possessing expert diagnostic knowledge and clients as the objects for assessment, solution-focused assessment emphasizes the client as the "assessor" who constantly self-evaluates what is the client wants, what may be feasible solutions to the problem to get closer to the desired future, what the goals of treatment are, what strengths and resources s/he has that can be used to get to the desired future, what maybe helpful in the process of change, how committed or motivated s/he is to make change a reality,

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

and how quickly s/he want to proceed with the change, etc (Lee et al., 2003; Lee, 2013). At the same time, SFBT therapists, are experts on the "conversation of change" who keep the dialogues going in search of a description of an alternative, beneficial, reality (de Shazer, 1994).

WHAT IS DIFFERENT ABOUT THERAPEUTIC PROCESS IN SFBT

In the therapeutic process section, we pointed out three unique characteristics of the SFBT approach to the therapeutic process: It defines the therapeutic process (and the mechanism of change) as the dialogue between therapist and client. It focuses on what is observable in this dialogue rather than inferences about what lies behind it. And it is based on research evidence from disciplines that study language process. As a result, SFBT therapists focus intensively on how they use language in therapy. In SFBT, therapists listen closely to their clients' language for what is important to the client, for what their clients might want, for evidence of client competencies and successes related to what they want, and for their client's own and external resources. The goal is to build an ever more detailed version of what clients want to be different as well as how, using their own and other available resources, they can go about achieving that version of what they want to happen.

SPECIFIC ACTIVE INGREDIENTS

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

NATURE OF THE CLIENT-THERAPIST RELATIONSHIP

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

FORMAT AND SESSION STRUCTURE

Main interventions are taken from de Shazer, et al. (2007).

A positive, collegial, solution-focused stance

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

Looking for previous solutions

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

Looking for exceptions

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

Questions vs. directives or interpretations

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

Present- and future-focused questions vs. past-oriented focus

The questions that are asked by SFBT therapists are almost always focused on the present or on the future, and the focus is almost exclusively on what the client wants to have happen in his life or on what of this that is already happening. When questions

are asked about the past, they are typically about how the client overcame a similar difficulty or what strengths or resources of the past they can bring to bear on achieving their preferred future. This reflects the basic belief that problems are best solved by focusing on what is already working and how clients would like their lives to be, rather than focusing on the past for its own sake and the origin of problems.

Compliments

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

Gentle nudging to do more of what is working

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

Specific Interventions:

Pre-session change

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

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

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

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

Solution-focused goals

Like many models of psychotherapy, setting personal salient, clear, specific, and attainable goals are an important component of SFBT. Whenever possible, the therapist tries to elicit smaller goals rather than larger ones. More important, clients are encouraged to frame their goals as the presence of a solution, rather than the absence of a problem. For example, it is better to have as a goal, "We want our son to talk nicer to us"—which would need to be described in greater detail—rather than, "We would like our child to not curse at us." In addition, the goal is framed as something that the client can regularly practice on his or her own and does not depend on the initiation of someone else. Also, if a goal is described in terms of its solution, it can be more easily scaled (see below). [2]

Miracle Question

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

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

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

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

Berg:	(Finishing the miracle question with …) So when you wake up tomorrow morning, what will be the first small clue to you... "whoa, something is different".
Dad:	You mean everything's gone: the kids...everything?
Mom:	No, no.
Berg:	The problem is gone.
Dad:	It never happened?
Mom:	The problem happened but it's all better.
Berg:	It's all handled now.
Mom:	To tell you the truth, I probably don't know how...we're waiting. I mean, we're waiting on that day. We're waiting on that day when there is just nobody.
Berg:	Nobody. No social service in your life.
Mom:	Yeah.
Berg:	How would you, when you sort of come out of sleep in the morning, and you look around and see, what will let you know... "wow, today is different, a different day today, something is different, something happened."
Dad:	The gut feeling. The inside feeling. The monkey off the back so to speak.
Berg:	O.K.
Dad:	When I had a drug problem..., I guess it's a lot of the time the same feeling.
	When I had a drug problem I always was searching, and just always something, I never felt good about it. You know.
Berg:	(Connecting to client words and meanings, ignoring the "complaint statements" and choosing one part of the client's message that is connected with what they want to feel differently) So, after this miracle tonight, when the miracle happens, the problems are all solved, what would be different in your gut feeling?
Dad:	Maybe I'd feel a little lighter, a little easier to move... not having to, ah, answer for my every movement.
Mom:	Uh huh. Being able to make decisions as husband and wife. As parents of kids. Without having to wonder, "did we make the right decision or are we going to be judged on that decision?"

Berg:	Oh.
Mom:	I mean, this is what we feel is best, but when we have to answer *our* decision to somebody else …
Dad:	Yeah, I mean "try it this way," or "try it that way," well, I mean, it's natural to learn a lot of those things on your own, I mean... I mean, you fail and you get back up and you try it another way.
Berg:	So you would like to make the decision just the two of you, you were saying, "hmm, this makes sense, let's do it this way" without worrying: "is someone going to look over our shoulder or not."
Mom & Dad:	Right.
Mom:	And whether we agree or whether we disagree. To have somebody, have somebody taking sides, you know, what is his point, what is my point, and then trying to explain to us, well...
Dad:	(Referring to social services) It was always having a mediator, I mean, ...
Mom:	Yeah, there's always somebody to mediate.
Berg:	So the mediator will be gone. Will be out of your life.
Mom & Dad:	Right.
Berg:	(Connecting again to client words/meanings; accepting and building) O.K. All right. All right. So suppose, suppose all these mediators are out of your life, including me. What would be different between the two of you? (Silence)
Dad:	(Sighs)
Mom:	Everything. Like I said, being able to look at each other as husband and wife and know that if we have, if we agree on something, that that is *our* decision, and that's the way it's going to be. If we disagree on something, it's a decision that, I mean, that's something we have to work out between us, and we don't have to worry what that third person's opinion is going to be, and I don't have to have a third person saying, "Yes, well, I agree, the way Keith decided it was right." Which makes me feel even *more* belittled.
Berg:	All right. So, you two will make decisions regarding your family. What to do about the kids, what to do about the money, going to do whatever, right?
Mom:	Right.
Berg:	Suppose you were able to do that without second guessing. What would be different between the two of you...that will let you know, "Wow! This is different! We are making our own decisions."
Mom:	A lot of tension gone I think. …

And so forth.

What clients are able to co-construct with the therapist in answer to the miracle question can usually be taken as the goals of therapy. With a detailed description of how they would like their lives to be, clients often can turn more easily to building enhanced

meanings about exceptions and past solution behaviors that can be useful in realizing their preferred futures.

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

Scaling questions

Whether the client gives specific goals directly or via the miracle question, an important next intervention in SFBT is to have the client evaluate his/her own current status. A number of scaling questions are possible and useful. In the first session, asking from 0-10, how willing the client is to actually *do* something to move towards their preferred future is helpful in assessing motivation for change. Clients can be asked their confidence level for achieving their goal on a 0-10 scale. The therapist can ask the Miracle Question Scale: From 0-10, where 0 means when the initial appointment was arranged and 10 means the day after the miracle, where are things now? For example, with a couple where better communication is their goal:

Therapist:	What I want to do now is scale the problem and the goal. Let's say a 0 is as bad as the problem ever could be, you never talk, only fight, or avoid all the time. And let's say a 10 is where you talk all the time, with perfect communication, never have a fight ever.
Husband:	That is pretty unrealistic
T:	That would be the ideal. So where would you two say it was for you at its worst? Maybe right before you came in to see me.
Wife:	It was pretty bad… I don't know…I'd say a 2 or a 3.
H:	Yeah, I'd say a 2.
T:	Ok (writing)… a 2-3 for you, and a 2 for you. Now, tell me what you would be satisfied with when therapy is over and successful?
W:	I'd be happy with an 8.
H:	Well, of course I'd like a 10, but that is unrealistic. Yeah, I'd agree, an 8 would be good.
T:	What would you say it is right now?
W:	I would say it is a little better, because he is coming here with me, and I see that he is trying… I'd say maybe a 4?
H:	Well that's nice to hear. I wouldn't have thought she'd put it that high. I would say it is a 5.
T:	Ok, a 4 for you, a 5 for you. And you both want it to be an 8 for therapy to be successful, right?

There are three major components of this intervention. First, it is an assessment device. That is, when used each session, the therapist and the clients have an ongoing

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

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

T:	Mary, last week you were a 4 on the scale of good communications. I am wondering where you are this week?
W:	[pause] I'd say a 5.
T:	A 5! Wow! Really, in just one week.
W:	Yes, I think we communicated better this week.
T:	How did you communicate better this week?
W:	Well, I think it was Rich. He seemed to try to listen to me more this week.
T:	That's great. Can you give me an example of when he listened to you more?
W:	Well, yes, yesterday for example. He usually calls me once a day at work, and…
T:	Sorry to interrupt, but did you say he calls you once a day? At work?
W:	Yes
T:	I'm just a little surprised, because not all husbands call their wives every day.
W:	He has always done that.
T:	Is that something you like? That you wouldn't want him to change?
W:	Yes, for sure.
T:	Sorry, go on, you were telling me about yesterday when he called.
W:	Well, usually it is kind of a quick call. But I told him about some problems I was having, and he listened for a long time, seemed to care, gave me some good ideas. That was nice.
T:	So that was an example of how you would like it to be, where you can talk about something, a problem, and he listens and gives good ideas? Support?
W:	Yes.
T:	Rich, did you know that Mary liked your calling her and listening to her? That that made you two move up the scale, to her?

H:	Yeah, I guess so. I have really been trying this week.
T:	That's great. What else have you done to try to make the communication better this week?

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

Constructing solutions and exceptions

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

Mother:	She always just ignores me, acts like I'm not there, comes home from school, just runs into her room. Who knows what she is doing in there.
Daughter:	You say we fight all the time, so I just go in my room so we don't fight.
M:	See? She admits she just tries to avoid me. I don't know why she can't just come home and talk to me a little about school or something, like she used to.
T:	Wait a second, when did she "used to"? Anita, when did you use to come home and tell your mom about school?
D:	I did that a lot, last semester I did.
T:	Can you give me an example of the last time you did that?
M:	I can tell you, it was last week actually. She was all excited about her science project getting chosen.
T:	Tell me more, what day was that…?
M:	I think last Wednesday.
T:	And she came home…
M:	She came home all excited.
T:	What were you doing?
M:	I think the usual, I was getting dinner ready. And she came in all excited, and I asked her what was up, and she told me her science project was chosen for the display at school.
T:	Wow, that is quite an honor.
M:	It is.
T:	So then what happened?
M:	Well, we talked about it, she told me all about it.

T:	Anita, do you remember this?
D:	Sure, it was only last week. I was pretty happy.
T:	And would you say that this was a nice talk, a nice talk between you two?
D:	Sure. That's what I mean; I don't always go in my room.
T:	Was there anything different about that time, last week, that made it easier to talk to each other?
M:	Well, she was excited.
D:	My mom listened, wasn't doing anything else.
T:	Wow, this is a great example. Thank you. Let me ask this: if it were like that more often, where Anita talked to you about things that were interesting and important to her, and where Mom, you listened to her completely without doing other things, is that what you two mean by better communication?
D:	Yeah, exactly.
M:	Yes

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

Coping questions

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

Taking a break and reconvening

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

T: I just wanted to tell you, the team was really impressed with you two this week. They wanted me to tell you that, Mom, they thought you really seem to care a lot about your daughter. It is really hard to be a mom, and you seem so focused and clear about how much you love her and how you want to help her. They were impressed that you came to session today, in spite of work and having a sick child at home. Anita, the team also

wanted to compliment you on your commitment to making the family better. They wanted me to tell you how bright and articulate they think you are, and what a good "scientist" you are! Yes, that you seem to be really aware of what small, little things that happen in your family that might make a difference… That is what scientists do, they observe things that seem to change things, no matter how small. Anyway, they were impressed with you two a lot!
D: [Seeming pleased.] Wow, thanks!

Experiments and homework assignments

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

T:	Before we end today, I would like for you two to think about a homework assignment. If you were to give yourselves a homework assignment this week, what would it be?
D:	Maybe that we talk more?
T:	Can you tell me more?
D:	Well, that I try to talk to her more when I come home from school. And that she stops what she is doing and listen.
T:	I like that. You know why? Because it is what you two were starting to do last week. Mom, what do you think? Is that a good homework assignment?
M:	Yeah, that's good.
T:	So let's make this clear. Anita will try to talk to you more when she comes home from school. And you will put down what you are doing, if you can, and listen and talk to her about what she is talking to you about. Anything else? Anything you want to add?
M:	No, that's good. I just need to stop what I was doing, I think that is important to listen to her.

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

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

In cases where the client has not been able to form a clear goal the therapist may propose that the client thinks about how he wants things to be by, for instance, using the FFST (formula first session task; de Shazer, 1992, 1994).

Ideas around what the therapist thinks might be useful for the client to observe may (and will often) be given with the end-of-session message. These will have something to do with what the client described in the miracle. The generic form of the FFST is: "Notice what is happening in your life that is related to your coming here from now to the next time we get together that you want to continue to have happen."

So, what is better, even a little bit, since last time we met?

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

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

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

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

COMPATIBILITY WITH ADJUNCTIVE THERAPIES

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

TARGET POPULATIONS

SFBT has been found clinically to be helpful in treatment programs in the U.S. for adolescent and adult outpatients (Pichot & Dolan, 2003), and as an adjunct to more intensive inpatient treatment in Europe. SFBT is being used to treat the entire range of clinical disorders, and is also being used in educational and business settings. Meta-analysis and systematic reviews of experimental and quasi-experimental studies indicate that SFBT is a promising intervention for youth and adults with internalizing disorders and behavior problems. SFBT has also been frequently used with school and academic problems, showing medium to large effect sizes (Gingerich & Peterson, 2013; Kim, 2013; Kim & Franklin, 2008).

MEETING THE NEEDS OF SPECIAL POPULATIONS

While SFBT may be useful as the primary treatment mode for many individuals in outpatient therapy, those with severe psychiatric, medical problems, or unstable living situations will most likely need additional medical, psychological, and social services. In those situations, SFBT may be part of a more comprehensive treatment program. Moderating analysis from Stams et al. (2006) meta-analysis found that SFBT had a

statistically significant effect when compared to clients who received no treatment (d= 0.57, $p < 0.01$) although that effect was not larger than those who received treatment as usual. Clients residing in institutions, including delinquents and patients with schizophrenia, benefited more from SFBT (d = 0.60) than did non-residential clients such as family/couples (d = 0.40) and students (d = 0.21). Two reviews of the research suggested that SFBT is efficacious with internalizing disorders such as depression (Kim, 2008; Gingerich, 2013).

SFBT is used in clinical and non-clinical settings all around the world. However, research is limited on the efficacy of SFBT with ethnic minority populations, especially in the United States. Although it is worth noting that there is sizeable amount of international research in Europe, Mainland China, Taiwan, Hong Kong, and Japan (Franklin & Montgomery, 2013) examining the effectiveness of SFBT on their population. Kim (2013) edited a clinical practice book on applying solution-focused brief therapy with minority clients and Corcoran's (2000) article provides a conceptual framework to help understand how SFBT may be effective with minority clients. As far as examining which ethnic minority group population SFBT has been applied to, Franklin and Montgomery (2013) provide a breakdown of the racial demographic characteristics from the various outcome studies reviewed. Results show that most of the people who received SFBT were Caucasian (71.7%), followed by African American (12.3%) and Hispanic (12.3%). It is worth noting that these numbers are similar to the United States (US) population proportions, which is important since most of the studies reviewed were conducted in the US.

THERAPIST CHARACTERISTICS AND REQUIREMENTS

SFBT therapists should posses the requisite training and certification in a mental health discipline, and specialized training in SFBT. The ideal SFBT therapist would possess (a) a minimum of a master's degree in a counseling discipline such as counseling, social work, marriage and family therapy, psychology, or psychiatry; (b) formal training and supervision in solution-focused brief therapy, either via university classes or a series of workshops and training experiences as well as supervision in their settings. Therapists who seem to embrace and excel as solution focused therapists have these characteristics: (a) are warm and friendly; (b) are naturally positive and supportive (often are told they "see the good in people"); (c) are open minded and flexible to new ideas; (d) are excellent listeners, especially the ability to listen for clients' previous solutions embedded in "problem-talk"; and (e) are tenacious and patient.

THERAPIST TRAINING

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

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

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

SUPERVISION

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

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APPENDIX A

Examples of Experimental and Quasi Experimental Designs

Author	Population	Sample Size	Setting	Measures	Results
Cockburn, et. al. (1997)	Orthopedic patients	48	Rehabilitation Program	F-COPES and PAIS-SR	Significant difference between traditional and SFBT on both measures.
Corcoran (2006)	Students aged 5-17	86	School	Conners' Parent Rating Scale; Feelings, Attitudes, & Behaviors Scale for Children	While both the experimental and comparison groups improved at posttest, no significant differences were found between groups on both measures.
Eakes (1997)	Families	10	Mental health clinic	Family environment scale	Significant between group differences on 4 of 11 dimensions of the scale.
Franklin, Moore & Hopson (2008)	Middle school students	59	Middle school	Child Behavior Checklist (CBCL)-Youth Self Report Form-Internalizing & CBCL Externalizing; Teacher's Report Form-Internalizing & Externalizing Score	SFBT group declined below clinical level by posttest and remained there at follow-up while comparison group changed little for Internalizing and Externalizing scores for Teacher Report Form as well as Externalizing score for Youth Self Report Form. No difference between the groups on Youth Self Report Form- Internalizing score.
Franklin, Streeter, Kim, & Tripodi (2007)	At-risk high school students	85	High schools	Credits earned and attendance	SFBT sample had statistically significant higher average proportion of credits earned to credits attempted than the comparison sample. Both groups decreased in the attendance mean per semester, however, the comparison group showed a higher proportion of school days attended to school days for the semester. Graduation rates also favored

					comparison group (90% to 62%).
Froeschle, Smith, & Ricard (2007)	8th grade females	65	Middle school	American Drug & Alcohol Survey; Substance Abuse Subtle Screening Inventory Adolescent-2; Knowledge exam on physical symptoms of drug use; Piers-Harris Children's Self-Concept Scale-2; Home & Community Social Behavior Scales; School Social Behavior Scales 2nd ed; Referrals; Grade Point Average	Statistically significant differences were found favoring SFBT group on drug use, attitudes towards drugs, knowledge of physical symptoms of drug use, and competent behavior scores as observed by both parents and teachers. No group differences were found on self-esteem, negative behaviors as measured by office referrals, and grade point averages.
Ingersoll-Dayton (1999)	Elderly	21	Nursing Home	Modified Caretaker Obstreperous -Behavior Rating Assessment	Family members and nurses' aide reported decrease in problem behaviors (wandering and aggression among residents) in both severity and frequency. Family members perceive problem behaviors as less problematic than nurses aide.
La Fountain (1996)	Elementary & High School Children	311	Elementary & High School	Index of Personality Character	Modest but statistically significant between-group differences were found on 3 sub-scales of the IPC: Nonacademic, Perception of Self, and Acting In. Differences suggest that students in the SFBT group had higher self-esteem in nonacademic arenas; more positive attitudes and feelings

					about themselves; and more appropriate ways of coping with emotions.
Lambert (1998)	Adult Couples	72	Private practice	Outcome questionnaire	36% of the 22 SFBT patients whose initial Outcome Questionnaire (OQ-45) scores were above 63 were recovered after 2 sessions of SFBT, and 46% were recovered after 7 sessions. (Recovery was defined as reliable change and were below the clinical cut-off score.) This compared with 2% of the comparison group recovered after 2 sessions of time-unlimited eclectic treatment, and 18% recovered after 7 sessions.
Lindforss & Magnuson (1997)	Adult criminal population	60	Swedish prisons	Recidivism	SFBT group less recidivism, less serious crimes at 12 and 16 months.
Newsome (2004)	Middle School Students	52	Middle School	Grades & Attendance	Statistically significant results with SFBT group increasing mean grade scores while the comparison group's grades decreased. No difference on attendance measure.
Springer, Lynch, & Rubin (2000)	Elementary Students	10	Elementary School	Hare Self-Esteem Scale	Statistically significant increase on the Hare Self-Esteem Scale for SFBT group but comparison group's scores remained the same from pretest to posttest. However, no significant differences were found between the two groups at the end of the study on the self-esteem scale.
Smock, Trepper, Wetchler, McCollum, Ray & Pierce (2008)	Level 1 substance abuse clients	38	Substance abuse outpatient clinic	Beck Depression Inventory; Outcome Questionnaire 45.2	SFBT group showed statistically significant improvement on both measures, with an effect size of 0.64 for the BDI and 0.61 for the OQ-45 Symptom Distress subscale. The Hazelden comparison group showed a positive trend on

					both measures but changes were not significant. The SFBT group had higher scores on both measures at pre-test, but by post-test the scores of the two groups were roughly comparable, thus between group differences at post-test did not reach statistical significance. Both groups were in the normal range of the OQ-45 at both pre-test and post-test.
Knekt, Lindfors, Härkänen et al. (2008)	Adults with anxiety & mood disorders	326	Outpatient Psychiatric Clinic	Beck Depression Inventory; Hamilton Depression Rating Scale; Symptom Check List Anxiety Scale; Hamilton Anxiety Rating Scale; Work Ability Index; Work-subscale of the Social Adjustment Scale; Perceived Psychological Functioning Scale; prevalence of patients working or studying; number of sick leave days	Statistically significant reduction of symptoms was noted for all four mental health and worker ability measures over the 3-year period for patients in all three treatment groups. SFBT and SPP produced benefits quicker (i.e., during the first year) than LPP, but LPP caught up with SFBT and SPP during year 2 and exceeded them at year 3. No differences among the three therapies at the 3-year follow-up on prevalence of individuals working or studying, or in number of sick-leave days.
Zimmerman, Prest, & Wetzel. (1997)	Couples	36	Marriage & Family Therapy Clinic	Marital status inventory and Dyadic Adjustment Scale	Significant difference between groups after treatment.

APPENDIX B

Microanalysis of SFBT Therapy Sessions:

There is a growing body of recent research, microanalysis of therapeutic dialogue, which is making the co-construction process increasingly observable. Microanalysis is a research method developed for experimental research, which involves the "close examination of (actual psychotherapy) conversations, moment by moment, utterance by utterance" (Bavelas, McGee, Phillips, & Routledge, 2000, p. 47). This research offers a clear and detailed description of what is happening as the SFBT therapist listens, selects, and invites the client to build towards a solution. It also makes visible how practitioner and client cooperate to put in place new meanings or understandings that are being co-constructed through their moment-by-moment interaction. In the following sections, SFBT listening, selecting, and building are described in greater detail and with more precision using the terminology and findings from research areas such as psycholinguistics and discourse analysis. Throughout, documented differences between SFBT and other therapies are identified.

Lexical Choice:

As emphasized above, solution-focused therapists carefully select the words that they use in their paraphrases, summaries, and questions. This deliberate selection of words and phrases that may have an effect on the recipient is called *lexical choice* (e.g., van Dijk, 1983). Broadly speaking, all microanalysis of SFBT sessions involve attention to the lexical choices of the therapists, but a recent study by Smock Jordan et al., (in press) made the therapists' and clients' choices of their words and phrases the direct focus of interest.

Building on work by Tomori (2004; Tomori & Bavelas, 2007), Smock Jordan et al. (in press) hypothesized that the lexical choices of SFBT and CBT therapists would differ in whether they used primarily *positive or negative* content. To illustrate positive and negative content, we can return to the dialogue between Korman and the young mother presented on pp. 5-6. At #1, the therapist asked: "What will have to happen, as a result of you [gestures toward her] coming here today—this afternoon, tomorrow, the day after tomorrow—for you to feel that it's been somewhat useful to, to be here?" This question is an example of positive content because it asked about what the client wanted to have happen in the future. Other types of positive content include statements or questions about:

- Solutions
- Resources
- Agency towards change
- Confidence
- Initiative
- Strengths or abilities

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* This document will continually be revised to reflect updates in clinical practice and research relevant to SFBT.

- Exceptions to the problem (e.g., past successes)
- Good situations in a person's life (e.g., support of others; a good job)
- Commenting on where he/she wants to be Stating what will be helpful
- Displaying optimism, hope about their situation
- Noting that something went well
- Details of a preferred future

An example of negative content occurred at #14 in the dialogue where the client said, "I'm in the process of going through a divorce." This phrase is negative because it mentions going through an unpleasant process. Other types of negative content include statements or questions about:

- Problems, weaknesses, or complaints
- Lack of resources, including financial or personal
- Feeling out of control
- Lack of confidence
- Lack of agency; inertia
- Helplessness
- Generalizing the problem; seeing no exceptions
- A bad situation (e.g., other people, lack of money)
- Failure or fear of failure
- Inability to see a solution
- Pessimism, lack of hope; hopelessness
- Negative emotions (e.g., fear, anxiety, depression, guilt)
- How difficult this problem is

Smock Jordan et al. (in press) analyzed the positive and negative content of therapists and clients in three SFBT and three CBT sessions conducted by experts in each approach. There were significant differences in their lexical choices, with SFBT therapists more likely to use positive content and CBT therapists more likely to use negative content. They also found that the therapist's lexical choice significantly affected the client's subsequent response, with positive lexical choices by therapists leading to positive client responses and negative lexical choices by therapists leading to negative client responses.

Grounding:

In order to understand how SFBT therapists and their clients cooperate to build or co-construct new understandings and possibilities for solution, it is necessary to understand a fundamental conversational process that psycholinguists call *grounding*. Clark and his colleagues (e.g., 1996; Clark & Schaefer, 1987, 1989; Schober & Clark, 1989) proposed that "understanding" is not an individual process in the participants' minds. It is a collaboration between the person who is the speaker at that particular moment and the addressee (i.e., the person being addressed). In any natural dialogue,

> Speakers and their addressees go beyond ... autonomous actions and collaborate with each other moment by moment to try to ensure that what is said is also understood. (Schober & Clark, 1989, p. 211)

Notice that the grounding process is not just an occasional explicit summary or agreement. It is a micro-process found in each of the moment-by-moment communication sequences that the participants are continuously creating. Indeed, Clark and Schaefer (1987, 1989) proposed that it is the basic format in which the participants contribute to their dialogue. We propose that with every grounding sequence, the participants in a dialogue are co-constructing (and aligning on) a shared version of whatever they are talking about, be it trivial or important.

SFBT researchers (Bavelas, De Jong, Korman & Smock Jordan, 2012; De Jong, Bavelas, & Korman, in press) have extended Clark and Schaefer's (1987, 1989) two-step model to a three-step sequence between the speaker and the addressee:

1. *The speaker presents some information*.
   E.g., Client says "I'm in the process of going through a divorce, so—.
2. *The addressee displays that he or she understood it, did not understand it, or is not sure.*
   E.g., the therapist nods. (The therapist displays that he understood.)
3. *The speaker acknowledges the addressee's display of understanding as correct or, alternatively, indicates that it was ambiguous or not correct.*
   E.g., The client says "I'm sure that's [gestures toward him] the majority of it." The client implicitly acknowledges his understanding by reducing what she had just said to a pronoun ("that's") and continuing the topic.

Each completed grounding sequence puts in place a piece of co-constructed information (i.e. an understanding or meaning) which then becomes common ground. The implication of this three-step model of collaboration is that each participant provides evidence of their mutual understanding to the other: the addressee displays what he or she understands, and the speaker confirms this understanding. Step by step, they weave their dialogue together.

The micro-nature of the grounding process can be observed in the first two grounding sequences of the dialogue between Korman and the young mother (in transcript above). At #1, the therapist asked a question which is step 1 in the first grounding sequence because the question *introduced new information* into the dialogue: "So, umm. Is it okay if we start like, uh (Pause) What will have to happen, as a result of you (gestures toward her) coming here today—this afternoon, tomorrow, the day after tomorrow—for you to feel that it's been somewhat useful to, to be here?" At #2, the client responded with hesitation and said "Um" which was step 2 in this grounding sequence because it *displayed* an understanding by the client that she had been asked a question. (Research by psycholinguists Clark and Fox Tree, 2002) has shown that, in English, an "um" indicates a delay in speaking, in this case, "I'm thinking about how to answer your

question.") At #3 in the dialogue, the therapist remained silent and settled into a listening posture, looking directly at the client with one hand holding his chin. These gestures by the therapist *acknowledged* the client's display at #2 as appropriate (or meaningful); by settling into a listening posture, he also conveyed that he was going to wait for the answer which he expected she would construct. Thus this was step 3 in the first grounding sequence and completed it. The understanding or common ground the two of them have observably co-constructed through their interaction at this point in their dialogue is simply that the therapist has asked the client a question.

The first step of the second grounding sequence occurred at #4 where the client *introduced the new information:* "I don't think I'm—" with a laugh, followed by a gesture toward the therapist and a slight shrug. The second step was the therapist at #5 nodding and saying "It's a difficult question," then gesturing and returning to his listening posture. These words and his gestures *displayed* his understanding that she was having difficulty answering his original question. The third step of this second grounding sequence was the client (at #6) overlapping the therapist's words at #6 and continuing her thought (begun at #4): " --am even looking that far ahead"; she then looked down, said "Um," and paused. Her words, gestures, and pause at #6 *acknowledged* that she understood that he had understood her difficulty answering him. Thus, the common ground they have put in place through this second grounding sequence is that the therapist has asked the client a question that she can take her time answering.

The therapist's display of understanding in the second grounding sequence was a good illustration of how grounding sequences quickly become overlapping, with one contribution having more than one function. When the therapist said at #5, "It's a difficult question," these words not only functioned as a display in the second grounding sequence (as explained above); they also introduced new information in the dialogue which was the first step in the next (third) grounding sequence. De Jong, Bavelas, and Korman (in press) provided more discussion and examples of how grounding often involves rapidly overlapping and highly efficient sequences as each piece of new information is itself grounded. (They also offer examples of when participants in a conversation fail to ground and how they repair their misunderstandings and disagreements.)

The fundamental mechanism of co-construction in therapy is the grounding process, in that all therapy conversations implicitly or explicitly rely on this collaborative process to create new understandings between therapists and clients. However, what varies among different therapies is what is put in place in the process of grounding. As will be explained below, it varies because therapists representing different models make different lexical choices, ask questions with different presuppositions and on different topics and formulate (paraphrase, summarize) differently what the client has said about themselves and their circumstances. These observably different lexical choices, formulations, and questions are the overt expressions of therapists' different assumptions about the nature of clients, their situations, and how to be useful to them. We have already explained and illustrated the lexical choices made by SFBT therapists and how they differ from those of therapists representing other models. We now turn to

the formulations and questions of SFBT therapists and how they differ from those of other types of therapists.

Formulations:

In everyday life, a *formulation* occurs whenever one of the participants in a conversation describes, summarizes, explicates, or characterizes what another participant has said (Garfinkel & Sacks, 1970, p. 350). In therapy, formulations have many names: *echoing*, *mirroring, summarizing*, *paraphrasing*, *checking understanding*, *reflecting*, *reframing*, *relabeling, normalizing, etc*. Through the process of grounding, formulations are one important way in which the therapist contributes to a co-created version of the client (and the client's situation) as it emerges in a therapy session (Korman, Bavelas, & De Jong, in press).

The reason why a therapist's formulations influence the version of the client and the client's situation in a therapy session is because formulations are not purely reflective or neutral as has often been taught to beginning practitioners. As Heritage and Watson (1979) pointed out, when one participant in a conversation responds by formulating what the other has said, the formulation inevitably *transforms* the original utterance. Korman et al. (in press) have shown that some of the words from the original utterance may be omitted, some may be preserved exactly and some may be preserved in an altered form with synonyms or condensed into demonstrative pronouns. Some of the words in the formulation may even be additions that come from that responder's frame of reference rather than what the client said.

Formulations are frequent in therapy conversations (Korman et al., in press). For example, in the first part of #23 of the therapy dialogue presented earlier, the therapist offered a formulation of what the client had said, bit-by-bit, in #4, #6, #8, #10, #12, #14, #16, #18, #20, and #22. Her aggregated words and his formulation were as follows:

> #4 - #22, Client: Um. I don't think I'm….. even looking that far ahead. Um. Maybe just ***to sort together*** everything I'm, I'm feeling. I don't exactly know what that is yet. I don't, I don't exactly know what's bothering me like. I mean I, I'm in the process of going through a divorce. So, I'm sure that's the majority of it. I just recently haven't been able to sleep too well and--. So I thought maybe this might ***help me sort out*** whatever I need ***to get my life*** back ***together*** [nervous laugh].
>
> #23. Therapist: ***Help you sort*** something ***out to get your life together***.

The therapist's formulation preserved the 12 bold and italicized words of the client and omitted 87 of her 99 words. His formulation clearly reflected SFBT therapeutic process because of the words he chose to preserve and omit. The words he preserved were initial constructions of what the client wanted from therapy, and they described positive goals ("help me sort out" and "get my life … together"). The words he chose to ignore were either descriptions of problems (the divorce, not being able to sleep) or expressions of uncertainty ("I don't know," "I guess," etc). It is typical for an SFBT

therapist to focus on what the client wants to get out of therapy rather than focusing on problems or uncertainty.

Formulations are one of the principal tools of co-construction because each formulation is a transformed understanding of what the client has expressed, which introduces new information into the dialogue. In the grounding sequence that ensues, the client often displays understanding and acceptance of the formulation, and the therapist acknowledges the client's correct understanding of his or her formulation. Thus, the formulation becomes a piece of common ground that has been put in place between them and is then available for the therapist and client to build on. For instance, the therapist can take the formulation and incorporate it into a question that invites the client to construct details consistent with the formulation, as happened in the second part of #23 of our example ("So what would be a feeling, uh, a thought, an action, something you would do or think or feel that would tell you that ***you were sort of getting your life together***). When the client had accepted and answered the question (at #26), then client and therapist could continue to co-construct a particular version of the client and the client's life, which started here at the beginning of a typical SFBT session.

Korman et al. (in press) have conducted a comparative analysis of the formulations made by SFBT, CBT, and MI expert therapists. They found significant differences in how different therapists transformed what their clients said. The formulations of SFBT therapists preserved a significantly higher proportion of the client's exact words and added significantly fewer of the therapist's own words and interpretations than did the CBT and MI formulations. Additional research by Froerer and Smock Jordan (2012; see also Froerer, 2009) also contributes to an understanding of how SFBT therapists compose *solution-building formulations*. In an analysis of the formulations of three master SFBT therapists, these researchers found that the formulations of all three were more likely to be positive than negative, and they preserved the client's language more often in their positive than in their negative formulations.

Questions:

SFBT therapists also use questions to build in solution-focused directions with their clients. The signature questions of SFBT therapists are the most written about and widely known aspect of the SFBT model. Much of the remainder of this treatment manual is devoted to discussing and illustrating these questions. While knowing the signature SFBT questions is important to being solution-focused with clients, it is also important to understand how questions function in any therapeutic dialogue. Questions are a tool that can invite clients to build in solution-focused directions or lead them in other directions, such as more problem-focused ones. Understanding how questions function in a dialogue can equip therapists to more knowledgeably and carefully compose their questions so that their questions more accurately reflect their assumptions about the nature of clients and client change.

The following analysis focuses on what Anderson and Goolishian (1992) called "not-knowing questions, that is, questions that ask about something that the questioner does

not know and invite the other person to provide the information. For example, at #1 in our dialogue example, the therapist asked the client:

> "What will have to happen, as a result of you coming here today -- this afternoon, tomorrow, the day after tomorrow -- for you to feel that it's been somewhat useful to, to be here?"

Because the therapist could not know what the client's goals were, this question was clearly a "not knowing" one.

For most of its history, psychotherapy has treated its questions as though they were simply information-gathering tools (Freedman & Combs, 1996). More recently, authors from several therapeutic approaches have been calling attention to the usefulness of questions as therapeutic devices (de Shazer et al., 1986; Epston & White, 1992; Haley, 1976; Selvini-Palazzoli, Boscolo, Cecchin, & Prata, 1980; Watzlawick, Weakland, & Fisch, 1974). More recently still, McGee (1999; McGee et al., 2005) proposed that therapeutic questions are co-constructive because they initiate a sequence in which the client provides responses that fit within the constraints of the therapist's approach. Recent experimental research has suggested that answering different kinds of questions may lead to different subsequent behavior (Healing & Bavelas, 2011).

As outlined in McGee (1999; McGee et al., 2005), the influence of a question begins with its *embedded presuppositions,* which are the unstated assumptions that frame any question. For example, the question quoted above (#1 in the dialogue example) presupposed that (a) something could happen in the next few days as a result of this therapy session, that (b) this something could make the client feel that it had been useful to come; that (c) the client was able to imagine what this something could be; and that (d) the client was able to put this something into words that the therapist could understand.

In McGee's model, once a question has been asked, the client is implicitly required to provide an answer. In order to be able to answer, though, the client has to make sense of the question with its particular presuppositions and then find a way to construct an answer that fits these. In doing so, the client effectively has grounded on the presuppositions in the question and has entered into co-constructing a version of his or her life that includes these presuppositions. In his microanalysis of a wide variety of therapy conversations, McGee pointed out that even though the presuppositions of therapeutic questions constrain the direction in which clients can answer, clients rarely comment on or challenge the presuppositions. If the client does comment on or challenge a question and its presuppositions, the therapist can quickly backtrack and modify the question in a way more acceptable to the client but still consistent with the therapist's approach (McGee et al., 2005, p. 380). Ordinarily, however, clients work hard to answer therapists' questions and thereby involve themselves "in a process of meaning making" with their therapists (McGee et al., 2005, p. 377).

The therapeutic dialogue between Korman and the young mother can again be used to illustrate these points about how questions function in face-to-face dialogues. After the therapist had posed his question (at #1), the client had to search for an answer that fit the question and its presuppositions, outlined above. At first (#2), the client hesitated and said only “Um.”. In #3, the therapist responded to her “um” by settling into a listening posture (Kendon, 1970). At #4 the client started to answer with “I don’t think I’m—” and then broke off with a shrug. At #5, the therapist responded to her delay in answering by formulating a reason (“It’s a difficult question”) and returned to his listening posture. In their exchanges from #6 through #22, the client constructed her answer, bit by bit, with the therapist participating in observable grounding sequences by displaying his understanding through non-interruptive nodding, other gestures, and an occasional minimal verbal response such as “Mm. Mm” and “Right.” Finally, once the client had constructed her answer, the therapist offered his formulation of it at #23 (“Help you sort something out to get your life together”), which displayed his understanding of her answer. Throughout this section (#2 to #22), the client’s responses were consistent with McGee’s model of how questions function in a face-to-face dialogue: She cooperated with the therapist’s question by working hard to address the question and its presuppositions and by providing an answer consistent with the presuppositions without commenting on or challenging them. In so doing, she participated in co-constructing the beginning of a definition of how both she and the therapist would know whether or not the session they were going to have would be useful to her or not.

It is easy to imagine that, had the therapist begun the dialogue with a different question, the co-construction would have started off in a different direction. For example, suppose the therapist had asked: “So what problem can I help you with today?” Here, the embedded presuppositions would have been that: (a) the client came to get help, that (b) there was a problem the client needed help with, that (c) the client was able to tell the therapist about the problem she needed help with, and that (d) the therapist was the one who would provide the help. The client would likely make sense of the question and its presuppositions, constrain her thinking to a problem that had brought her there, and then construct an answer that would fit, such as describing her problem in detail. As McGee et al. (2005, p. 381) summarized, “(the client) discovers and presents information consistent with the embedded presuppositions. So whether the client discovers, on the one hand, abilities and positive qualities or, on the other hand, disabilities and pathology, he or she has been intimately involved in co-constructing this new common ground.”