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Solution-Focused Brief Therapy

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[−] Abstract and Keywords

Building on a strengths perspective and using a time-limited approach, solution-focused brief therapy is a treatment model in social work practice that holds a person accountable for solutions rather than responsible for problems. Solution-focused brief therapy deliberately utilizes the language and symbols of “solution and strengths” in treatment and postulates that positive and long-lasting change can occur in a relatively brief period of time by focusing on the solution-building process instead of focusing on the problems. Currently, this practice model has been adopted in diverse social work practice settings with different client populations, which could be partly accounted by the fact that the assumptions and practice orientation of solution-focused brief therapy are consistent with social work values as well as the strengths-based and empowerment-based practice in social work treatment.

Keywords: brief treatment, empowerment-based, social work treatment, solution-focused, strengths-based

History

The development of solution-focused brief therapy was originally inspired by the work of husband and wife Steve de Shazer and Insoo Kim Berg, along with their associates at the Brief Family Therapy Center in Milwaukee. The Brief Therapy Center was first established by de Shazer and Berg in 1978 and formally became the home of solution-focused brief therapy in 1982. With the passing of de Shazer in September 2005 and then Berg in January 2007, the stewardship of the Brief Therapy Center was transferred to the Solution-Focused Brief Therapy Association (SFBTA). De Shazer was instrumental in the development of SFBTA because he was the one who first invited the solution-focused community to meet in 2001. This group, including de Shazer, Berg and 27 colleagues, founded the SFBTA in the fall of 2002. The European Brief Therapy Association (EBTA), which was established earlier in 1993, shares similar aims to promote the development and dissemination of solution-focused brief therapy. Both the SFBTA and the EBTA hold annual conferences, support research efforts, and further the development and promotion of solution-focused brief therapy in practice.

When de Shazer and Berg first conceptualized the approach, solution-focused brief therapy was atheoretical, and the focus was on finding “what works in therapy.” Wary of the potentially limiting effects of assumptions or presumptions of theory-based practice approaches pertaining to clients, problems, and diagnoses, these pioneers of solution-focused brief therapy took a new and different approach in exploring the treatment process by asking one simple question: “What works in treatment?” They were interested in listening to what clients have to share, noticing what actually happens in session that helps positive improvement, and distancing themselves as much as possible from presumptions about what works as proposed by diverse treatment approaches. The original team regularly met and observed therapy sessions using a one-way mirror. While observing the therapeutic dialogues and process, the team behind the mirror diligently attempted to identify, discover, and converse about what brought beneficial positive changes in clients and families. In other words, the early development of solution-focused brief therapy was antithetical to the modernist epistemology of understanding human behavior and change based on a presumed understanding of the observed phenomena. Instead of taking a positivistic, hierarchal, or

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expert stance, the understanding is accomplished by a bottom-up and grounded approach, which strives for a contextual and local understanding of what works in therapy (Berg, 1994; Lee, 2011).

De Shazer, the co-founder of solution-focused brief therapy, was trained in brief therapy at the Mental Research Institute (MRI) in Palo Alto, CA. Consequently, the brief therapy tradition at MRI does have some legacy on the development of solution-focused brief therapy. Brief therapy, as based on MRI, is influenced by a systems perspective (Bateson, 1979), social constructivism (for example, see Berg & Luckmann, 1966; Neimeyer & Mahoney, 1993; Rosen & Kuehlwein, 1996), and the work of the psychiatrist Milton Erickson, who was an expert in observing and utilizing what clients brought to the session in order to solve their presenting problems. Erickson's work exemplified the belief that individuals have the strengths and resources to solve their problems (Erickson, 1985A; Erickson, 1985B). To note, a major difference between MRI and solution-focused brief therapy is that while the brief therapy approaches that were developed at MRI focus on disrupting the problem-maintaining pattern, solution-focused brief therapy emphasizes the solution-building process. Such a shift in treatment focus is influenced by a strong emphasis on the role of language in creating and sustaining reality as embraced by solution-focused brief therapy (de Shazer, 1994).

Practice Assumptions of Solution-Focused Brief Therapy

Insoo Kim Berg, Steve de Shazer, and the solution-focused community emphasized that solution-focused brief therapy is not simply a set of therapeutic techniques but instead represents a way of thinking (de Shazer, 1985). Mastering the techniques without embracing underlying assumptions and beliefs of solution-focused brief therapy toward clients and change is not helpful in the treatment process. While the original development of solution-focused brief therapy was atheoretical, the practice of solution-focused brief therapy is consistent with the views posed by a systems perspective, social constructivism, and the work of the psychiatrist Milton Erickson. The practice assumptions of solution-focused brief therapy are:

Focus on solutions, strengths, and health. Solution-focused brief therapy focuses on what clients can do versus what clients cannot do. Instead of focusing and exploring clients' problems and deficiencies, the focus is on the successes and accomplishments when clients are able to satisfactorily address their problems of living. The focus is on how to notice, identify, expand, and use these successes them more often (Berg & Kelly, 2000; de Shazer, 1985). The emphasis on solutions and successes is neither a consequence of "naive" beliefs regarding strengths in clients nor simplistic "positive thinking." It is a deliberate therapeutic choice, which is supported by repeated clinical observations that clients discover solutions more quickly when the focus is on what they can do, what strengths they have, and what they have accomplished (de Jong & Berg, 2013). Theoretically speaking, the focus on solutions and successes to facilitate positive changes in clients is supported by a systems perspective (Bateson, 1979) and the role of language in creating reality (de Shazer, 1994).

Systems perspective. One major proposition of a systems perspective is that change is constant in any system (Bateson, 1979). Because change is constant and there is movement in any system, every problem pattern includes an exception to the pattern (de Shazer, 1985). For example, no matter how conflicted a relationship is, there must be times that the dyads (that is, a couple or two people) are not fighting or bickering. The time when the dyad is doing something else to handle its differences constitutes an exception to the problem pattern, which also contains potential solution to the problem of fighting. Underlying such a view is a belief in the inherent strengths and potentials of clients to engage in behavior that is outside the problem pattern (De Jong & Berg, 2013). In other words, despite the multi-deficiencies and problems that clients may perceive that they have, there are times when clients handle their life situations in a more satisfying way or in a different manner. These exceptions provide the clues for solutions (de Shazer, 1985, 1988) and represent the client's "unnoticed" strengths and resources. The task for the solution-focused practitioner is to assist clients in noticing, amplifying, sustaining, and reinforcing these exceptions, regardless of how small or infrequent the exceptions may be (Berg & Kelly, 2000, Lee, Sebold, & Uken, 2003). Once clients are engaged in non-problem behavior, they are on their way to a solution-building process (Berg & Steiner, 2003).

Another major assumption of a systems perspective is the inter-relatedness of all parts of a system, which

presumes that everything is connected. Change in one part of a system leads to change in other parts of the system (Bateson, 1972; Becvar & Becvar, 2012; Keeney & Thomas, 1986). As such, a systems perspective does not assume a one-to-one linear relationship between problem and solution. The focus is on circular relationships rather than linear relationships among different parts of a system. The complex inter-relatedness of different parts of systems also renders the effort to establish a causal understanding of problems essentially futile. It is almost impossible to precisely ascertain exactly why any problem occurs in the first place and the trajectory of development. As such, solutions to a problem can happen in multiple pathways and do not necessarily have to be directly related to the presenting problem (de Shazer, 1985). In other words, insight into the problem's origin is not necessary to initiate a process of change in clients. Without minimizing the importance of a person's experience and perception of the history of the problem, solution-focused brief therapy views what is going on in the present as more important than what caused the problem at the very beginning.

The choice of not drilling into the history and patterns of problem but focusing on what clients do well is further influenced by the power of language in shaping clients' experience of their reality (de Shazer, 1994; Lee et al., 2003).

Language and reality.

There is a conscious effort in solution-focused brief therapy to stay focused on solution dialogues and to de-emphasize problem dialogues. Such a conscious effort grows out of a concern about the role of language in creating or sustaining reality. Solution-focused brief therapy views language as the medium through which personal meaning and understanding are expressed and socially constructed in conversation (de Shazer, 1991, 1994). Furthermore, the meaning of things is contingent on the contexts and the language within which issues are described, categorized, and constructed by clients (Wittgenstein, 1958). Wittgenstein (1958) suggested that the way an individual experiences the reality is framed and limited by the language available to him or her to describe it. As such, these meanings are inherently unstable and shifting (Wittgenstein, 1958). Consequently, a major therapeutic task for social work professionals is to consider how we can use language in treatment that will facilitate the description and construction of a "beneficial" reality that will open space for individuals to find solutions to their presenting problems.

Recognizing the power of language in creating and sustaining realities, the "conversation of change" is the preferred language of solution-focused brief therapy. The "conversation of change" uses language with the following characteristics (Lee, et al, 2003):

- Language that implies the person wants to change
- Language that implies that the person is capable
- Language that implies change has occurred or is occurring
- Language that implies the changes are meaningful
- Language that encourages the person to explore possibilities for change
- Language that suggests that the person can be creative and playful about life
- Language that conveys recognition of the persons' evolution of their personal story
- Language that does not encourage negative, blaming, or self-defeating descriptions

This "conversation of change" uses presuppositional language that assumes a possibility of change and thereby induces hopefulness in clients (Lee et al., 2003; Walter & Peller, 1992).

Accountability for Solutions

- Practitioners of solution-focused brief therapy choose to hold the client responsible for solutions instead of problems in the treatment process in order to ethically and effectively facilitate positive changes in clients (de Shazer, 1985). The advantage of such a focus is that the practitioner and the client can direct therapeutic efforts toward supporting the client's responsibility for building solutions and avoiding the potential negativity cycle that might be perpetrated by the language of blaming (Lee et al., 2003). However, holding clients to be accountable for solutions is neither simple nor easy. Clients usually seek treatment because they do not know or even feel that there are solutions to their presenting problems. Change requires hard work and a solution-building process requires discipline and effort (Berg & Kelly, 2000; De Jong and Berg (2013). In solution-focused treatment, the "solution" is established in the form of a goal that is to be self-determined and attained by the client (Lee, Uken,

& Sebold, 2007). Characteristics of useful goals are:

- personally meaningful and important to the clients;
- small enough to be achieved;
- concrete, specific, and behavioral so that indicators of success can be established and observed;
- positively stated so that the goal represents the presence rather than the absence of something;
- realistic and achievable within the context of the client's life; and (6) perceived as involving hard work (Berg & Miller, 1992; Lee et al., 2007).

A Present and Future Orientation

People can take helpful actions to impact the present and the future, but obviously we cannot change what has already happened in the past. Solution-focused brief therapy believes that problems belong to the past while solutions exist in the present and future. Solution-focused brief therapy assumes that the meanings of a problem are artifacts of the context (de Shazer, 1991). Because one can never know exactly why a problem exists and because problem perceptions are not external objective "realities," insight into the problem's origin is not necessary to initiate a process of change in clients. Without minimizing the importance of the client's experience and perception of the history of the problem, a solution-focused practitioner listens attentively to clients' sharing of their stories and experiences. However, the practitioner does not reinforce this line of conversation and instead looks for opportunities to shift to a "conversation of change" that assists clients in "staying at the surface of their problems" (de Shazer, 1991). "Staying at the surface of problems" should not be equated with being superficial in the treatment process. The treatment process avoids going "deep" into the problem; rather, it aims to assist clients to do something attainable and observable in their present, immediate life context (de Shazer, 1994). Solution-focused brief therapy acknowledges that we cannot change the past but assumes that we can do something helpful in the present.

Solution-focused brief therapy also assumes that "the future exists in our anticipation of how it will be" (Cade & O'Hanlon, 1993, p. 109). In other words, how we construct a picture of a desirable future will influence how events will unfold in life. Consequently, the solution-focused practitioner asks questions that will help clients to describe a future that does not contain the problem. The more specific and clearer the vision of a desirable future, the more likely it will happen because the client will have a goal to aspire to and steps to follow. Consequently, the task of therapy is to help clients envision a desirable future and identify the first small step that they can take to attain a future without the problem (Berg, 1994, De Jong & Berg, 2013). Such descriptions also inspire hope and enhance motivation in clients to engage in beneficial behaviors that will lead to positive changes in their lives.

Clients define their goals: The client as assessor

Solution-focused brief therapy views goals as individually constructed by clients in a collaborative process during treatment. Aligned with social constructivism (Berg & Luckmann, 1966; Neimeyer & Mahoney, 1993; Rosen & Kuehlwein, 1996), solution-focused brief therapy believes that solutions to problems are not objective "realities" but rather individually constructed. Clients are the most legitimate "knower" of their life experiences and should be the center of the change process. Externally imposed therapeutic goals, as promoted by therapy approaches or society, may be inappropriate or irrelevant to the needs of clients. In addition, clients generally are willing to work harder if they define the goal of therapy and perceived the goal as personally meaningful (Lee et al., 2007). Consequently, a distinctive characteristic of solution-oriented assessment is its focus on the client as the assessor (Lee et al., 2003). Contrary to most medical models of assessment, which 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 the problem is, what may be feasible solutions to the problem, what the desirable future is, what the goals of treatment are, what strengths and resources the client has, what may be helpful in the process of change, how committed or motivated the client is to make change a reality, and how quickly the client wants to proceed with the change, etc (Lee et al., 2003). Solution-focused practitioners are experts on the "conversation of change" and keep the dialogues going in search of a description of an alternative and beneficial reality (de Shazer, 1994).

Collaborative therapeutic relationship.

This view of clients as the assessor fundamental shifts the relationship between the client and the social work practitioner, so that it is no longer a hierarchical relationship but rather a collaborative one, with the client as the assessor and the social work practitioner as an expert of the conversation of change. Clients no longer simply provide “data” for professionals to use in determining a diagnosis and a treatment plan. The role of the solution-focused practitioner is to provide a therapeutic context for clients to construct and develop a personally meaningful goal. The practitioner enters into their perspective, adopts their frame of mind, listens to and understands their goals, and looks for strengths instead of weaknesses or diagnoses (Lee, 2011). Instead of being hierarchical, the solution-focused practitioner-client relationship is an egalitarian and collaborative relationship in which both the client and social work professional work together to facilitate positive changes (de Jong & Berg, 2013). This collaborative relationship inherently enhances the process of engagement and client’s ownership of the treatment process.

Utilization.

Milton Erickson was an expert in utilizing clients’ symptoms to help resolve their presenting problems. He firmly believed that individuals have the strengths and resources to solve their problems and that the main therapeutic task is to uncover and activate these resources in clients (Haley, 1973). Influenced by Erickson’s work, solution-focused practitioners utilize whatever resources clients bring with them, whether these are skills, knowledge, beliefs, motivations, behaviors, symptoms, social networks, circumstances, and personal idiosyncrasies, to uncover the solution (de Shazer, 1985; O’Hanlon & Wilk, 1987). Such a practice orientation is based on several beliefs: (1) there is the presence of exception in every problem situation (de Shazer, 1985); (2) instead of attempting to teach clients something new or foreign based on the practitioner’s presumed notions of what is best for the client, it is usually more efficient to focus on what clients are doing when they engage in non-problem behaviors; (3) utilizing and building on exceptions is a more efficient and effective way for clients to develop solutions that are relevant to and viable in their unique life circumstances as opposed to suggestions from professionals; (4) people are usually more invested in solutions that they discover or identify by themselves. As such, the task for the solution-focused practitioner is to elicit, trigger, reinforce, expand, and consolidate the exceptions that the client generates. Solution-focused practitioners stay away from teaching clients skills or intervening in their lives in ways that may fit our “model” of what is good, but may not be appropriate or viable in their lives (Lee, et al., 2003; Lee, 2011).

Tipping the first domino: A small change.

“A journey of a thousand miles begins with one step” (Laozi, *Dao Te Ching*, Chapter 100) Solution-focused brief therapy fully embraces the wisdom of beginning the change effort with the first, small step. There are many benefits of focusing on the first small step: (1) small changes are more feasible, doable, attainable, and manageable than big changes; (2) small steps provide indicators of improvement; (3) people are usually more encouraged and committed to the change process when they experience successes; and (4) small successes provide feedback for more successes in the process of change. Change requires both the vision of a “big” picture and a pragmatic plan for the first small step.

The emphasis on the first small step is also influenced by systems perspective. Introducing any change in a system may disturb a person’s equilibrium in unpredictable ways as a result of reiterating feedback. Repetitive attempts at the same unsuccessful solution are precisely what create problems in the first place (Watzlawick, Weakland, & Fisch, 1974). Consequently, solution-focused brief therapy believes that the best responses to client’s problems involve minimal, but personally meaningful, intervention by the solution-focused practitioner into their lives (Lee et al., 2003). Clients should determine what constitutes acceptable solutions. The most important thing is for practitioners to help clients identify the first small behavioral step toward desirable change.

The Solution-Focused Treatment Manual adopted by SFBTA succinctly describes the basic tenants of solution-focused brief therapy. It can be found at: <http://www.sfbta.org/researchDownloads.html> (Trepper, McCollum, De Jong, Korman, Gingerich, & Franklin, 2010).

Solution-Focused Interventions

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Solution-focused interventions engage the client in a “conversation of change” that is conducive to the solution-building process. In this conversation, the solution-focused practitioner invites the client to be the “expert of change.” Collaboratively, the solution-focused practitioner and the client co-construct a desirable future that does not contain the problem. The practitioner listens intensely and explores the meaning of the client’s perception of his or her situation. Practitioners utilize solution-oriented questions, including exception questions, outcome questions, coping questions, scaling questions, and relationship questions to assist clients in constructing a reality that does not contain the problem. De Shazer, Berg, and their colleagues develop these questioning techniques to fully utilize the resources and potential of clients (for example, Berg & Kelly, 2000; de Jong & Berg, 2013; de Shazer, 1985). Questions are perceived as better ways to create open space for clients to think about and self-evaluate their situation and solutions.

First session.

In terms of the treatment process, clients are first oriented to a solution-focus frame in which the focus of therapy is to assist clients in finding solutions to their problems with as few sessions as needed. The clients are immediately encouraged to give a clear and explicit statement of their presenting complaint. Without focusing on the history of the problems, the solution-focused practitioner uses solution-building questions to begin assisting clients in identifying solutions for their problems. Specific interventions include:

- *Pre-session change.* Early in treatment, the solution-focused practitioner helps clients to notice positive changes in their natural environment before they receive any treatment. “What changes have you noticed that have happened or started to happen since you called to make the appointment for this session? (Trepper et al., 2010). Pre-session change assumes that change is ongoing and is initiated by the clients and not the professionals.
- *Exception questions* inquire about times when the problem is either absent, less intense, or dealt with in a manner that is acceptable to the client (de Shazer, 1985). The solution-focused practitioner presupposes that change is happening in the client’s problem situation. Such an effort shakes the rigid frames constructed by many clients with respect to the pervasiveness and permanency of their complaints. Examples of exception questions include: When was the last time that you didn’t have this problem? When was the last time that you expected that you’d have the problem but it did not happen? When was the last time that you thought you would lose your temper but you didn’t? What was different about these times?
- *Miracle questions* allow clients to separate themselves from their problem-saturated context and construct a future vision of life without the presenting complaint or with acceptable improvements in the problem. Miracle questions foster a sense of hopefulness and offer an opportunity for clients to develop a beneficial direction for improving their lives. The focus is on identifying small, observable, and concrete behaviors that are indicators of small changes, which can make a difference in the client’s situation (de Shazer, 1985). A widely used format of miracle question is: *Suppose that after our meeting today, you go home, do your things, and go to bed. While you are sleeping, a miracle happens and the problem that brought you here is suddenly solved, like magic. The problem is gone. Because you were sleeping, you don’t know that a miracle happened, but when you wake up tomorrow morning, you will be different. How will you know that a miracle has happened? What will be the first small sign that tells you that the problem is resolved?* (Berg & Miller, 1992). Variations of the miracle question include the dream question (Greene, Lee, Mentzer, Pinnell, & Niles, 1998) and the nightmare question (Reuss, 1997).
- *Coping questions* help clients to notice times when they are coping with their problems and what they are doing when they are successfully coping. Asking coping questions indirectly reframes the meaning frames of clients who have assumed that they are entirely helpless and thus they have no control over the problem situation (Berg, 1994; Berg & Steiner, 2003). Examples of coping questions include: *How have you been able to keep going despite all the difficulties you’ve encountered? How are you able to get up despite being so depressed?* A newly developed question is the “lemon question” that embraces personal pride and dignity in assisting clients to look for personal strengths in coping with difficult situation: *Suppose you came to see, with a new clarity, that _____ [a normalized statement of the difficult life predicament in which the clients find themselves], what would you be most proud of as your response to that situation?* (Taylor, 2012).
- *Scaling questions* ask clients to rank their situation or goal on a 1-to-10 scale (de Jong & Berg, 2013). Usually, 1 represents the worst scenario that could possibly be and 10 is the most desirable outcome. Scaling questions

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provide a simple tool for clients to quantify and evaluate their situation and progress so that they can establish a clear indicator of progress for themselves. Some examples of commonly used scaling questions are: *On a 1-to-10 scale, with 1 being the worst the problem could possibly be and 10 as the most desirable outcome, where would you put yourself on the scale? On a 1-to-10 scale with 1 being you don't believe you can do anything to change the situation and 10 meaning you are absolutely determined to do something to change the problem, how would you put yourself on the scale? What would your wife say using the same scale?"*

- *Relationship questions* ask clients to imagine how significant others in their environment might react to their problem or situation and changes they make (Berg, 1994; de Jong & Berg, 2013). Relationship questions recognize the interactional aspect of many problems. These questions not only contextualize problem definition but also the client's desired goals and changes. In addition, relationship questions help establish multiple indicators of change as grounded in clients' real life context. Examples of relationship questions include: *Who would be the first to notice changes in you? What would your friends notice that is different about you if you are more comfortable with the new college environment? How would your mother rate your motivation to do something different and helpful on a 1-to-10 scale?*

Taking a break.

Solution-focused practitioners are encouraged to take a break near the end of the session prior to wrapping up the session. The break serves several important functions: (1) the practitioner can consult with his or her team or supervisor about the session and solicit ideas and feedback for complimenting and providing solution-focused interventions to the client; (2) the practitioner can use the time to organize his or her thoughts and develop with compliments and ideas for possible interventions (Berg, 1994; Trepper et al., 2010); and (3) the break prepares the client or family to focus and receive the feedback from the solution-focused practitioner.

The end-of-session message usually consists of three components: a compliment, a bridging statement, and tasks. The compliment helps the client or family to clearly notice, register, and anchor what they have done well, what might be helpful in the change process, and what things that they should be proud of, and so on. Authentic compliments serve to motivate and direct clients for positive changes. A bridging statement serves to connect the compliment with the solution-focused tasks and experiments. An example of an end-of-session message is:

Apparently, you are determined to be a better mom for your children despite your kids being in foster care right now. Some parents might choose to distance from their children because of the pain of not able to be with them and you are determined not to let that pain takes control over you (compliment). Since you are such a keen observer (bridging statement), between now and next time we meet I would like you to observe, what happens in your daily life and in particular your interaction with the child welfare people that you want to continue to have happen more often so that you have a better chance to reunite with your children in the near future (observation task).

Solution-focused tasks and experiments.

Solution-focused brief therapy routinely uses task assignments and experiments to assist clients in noticing solutions in their natural life context (de Shazer & Molnar, 1984; Molnar & de Shazer, 1987). Some common solution-focused tasks and experiments are:

- If clients can identify exception behaviors to the problem, then clients are asked to "do more of what works."
- For clients who focus on the perceived stability of their problematic pattern and fail to identify any exceptions, an observation task is given: "Between now and next time we meet, we (I) want you to observe, so that you can tell us (me) next time, what happens in your (life, marriage, family, or relationship) that you want to continue to have happen" (Molnar & de Shazer, 1987). Another observation task directs clients to notice what they do when they overcome the temptation or urge to engage in the problem behavior.
- Other tasks that assist clients in interrupting their problem patterns and developing new solutions include: *Do something different* ("Between now and next time we meet, do something different and tell me what happened") and the *prediction task*, which asks the client to predict his or her behavior by tossing a coin ("If it is heads, do what you normally do; if it is tails, pretend that the miracle day has happened") (Berg, 1994).

Second session and after.

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The focus of second session and afterwards is on facilitating clients to notice and expand changes that have happened or were observed between sessions. A typical question is the “What’s better?” question: *So, what is better, even a little bit, since last time we meet?* (Berg, 1994; Trepper et al., 2010). Noticing change is a small but important step for clients to realize their desired future. The solution-focused practitioner continues to use solution-focused questions and interventions to elicit, amplify, and consolidate positive goal efforts that are demonstrated by the client. An important skill is to encourage clients to describe their small change effort in great detail so that the “ordinary” becomes “extraordinary” (Lee et al., 2003). Another important therapeutic task in the second session is to help clients notice the connection between their behaviors, feelings, thoughts, and their desired solutions. Examples of these questions include: *How are you able to go out together for a walk four out of seven days last week? How did both of you do that? How did you feel when you decided to stop arguing instead of exploding despite your anger? What’s in your mind when you chose not to talk back and argue with your parents?*

It is not uncommon for clients become distracted by problems, for things to not get better, or for clients to have not acted on the solution-focused tasks, and so on. From a solution-focused perspective, there is no good or bad response, because clients’ responses are just feedback to the practitioners to continue co-construct a beneficial reality with the clients (Lee et al., 2003). In other words, there is no failure because responses are just feedback (de Shazer, 1985). Oftentimes, clients might have overlooked the small change or been distracted by problems. The trick is for the solution-focused practitioners to remain persistent and patient. It is helpful to ask the client to restate in a different way his or her goal and the things that he or she has noticed. The task is to help the client to look for small changes that can be further amplified and expanded. Other times, the client might need to reevaluate his or her goals based on experimentation. People might need to experiment using trial and error to determine what is important and helpful to them. When clients do not improve or have done nothing by the second session, it is likely that the stated goals or tasks are not important, not appropriate, or not relevant to the extent that the clients are committed to do something different. It is important for the practitioner to offer choices as much as possible and to continue helping the clients to self-assess what might be beneficial for them. Solution-focused practitioners should not view clients as resistant or unmotivated. Instead, they should look for ways that clients are cooperating (Lee et al., 2003).

The solution-building process is allows the clients to notice a difference that can make a difference in their lives in their natural environment. The solution-focused practitioner cautiously refrains from providing or suggesting solutions. The solution-focused practitioner is responsible for creating a therapeutic dialogical context in which clients experience a solution-building process that is initiated from within and grounded in clients’ cultural strengths as well as their personal construction of the solution reality (Lee, 2003). It is for clients to discover what works for them in their unique life context.

Termination.

The goals of termination in solution-focused brief therapy is to (1) review goals and discuss progress; (2) facilitate clients to own and take full credit for their improvement and positive changes; (3) assist clients in developing connections between their actions and positive change efforts; and (4) assist clients in establishing indicators of relapse and follow-up measures. Oftentimes, the solution-focused practitioners use scaling questions to help clients evaluate differences in their presenting problem between now and before: *Suppose when we first started meeting, your problem was at a 1 and where you wanted to be is at a 10. Where would you say you are at today on a scale of 1-to-10? In addition, scaling questions are used to evaluate the clients’ confidence in their ability to maintain change: On a scale of 1-to-10, with a 10 meaning that you have every confidence that you will keep up with your progress and a 1 meaning that you have no confidence at all to maintain the change, where would you put yourself today? What would it take for you to move from a 5 to a 6?*

In addition to complimenting clients for the positive change efforts, one major solution-focused intervention at termination is to use questions that assist clients to make connections between their actions and positive changes as well as to take ownership of the change. *Looking back, what have you done to help you in making these changes? How do you decide that you are determined to make the change despite not being easy? “When did you decide to do that?” “Where do you think it comes from for you, the commitment?”*

Change will be more long lasting when clients are able to consolidate their changes into alternative, beneficial “self-descriptions” such as an honest man, a caring parent, or a loving husband. These descriptions encapsulate

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the overall change so that clients develop “the language of success” in place of the “language of problem” in describing the self (Lee et al., 2003). *How would you describe yourself as a husband now as compared to when we first met a few months ago?*

In addition to consolidating change efforts, it is important to help clients prepare for the ups and downs in life. Solution-focused practitioners use scaling and relationship questions to assist clients establish earliest indicator(s) of relapse and develop contingency plan: *What will need to happen in order for you to slide back again? What you will need to do to prevent that happen again? What would be the earliest sign to you that you are starting to go backward? When you notice that you are sliding back, what can you do differently to pull yourself up?*

Solution-focused brief therapy takes a developmental perspective in viewing change. In other words, there are always ups and downs in life, and clients might need to seek help again in the future for different problems of living, which is normal and not an indicator of failure. The important thing is for clients to learn something new and useful each time that they can use in addressing future problems.

In sum, solution-focused brief therapy advocates for an open process of self-evaluations and choice making through a “conversation of change.” There is no longer an objective problem or reality that exists independently outside the client. Treatment is essentially an ongoing and open process in which the client and the social work practitioner actively engage in co-constructing an inherently unstable reality that is different from the problem reality and contains the desirable future as defined by the client. The practitioner listens for and absorbs clients’ descriptions, words, and meanings, and then formulates responses by building on clients’ frames of reference and connecting to clients’ words and meanings. This cyclical and ongoing process of listening, connecting, and responding allows solution-focused practitioners and clients to co-construct a new, alternative, and beneficial solutions or desired future as determined by the clients (Trepper, 2010). Assessment and treatment are no longer alienated procedures operated on the client by an expert. Instead, treatment focuses on co-constructing a “conversation of change” that deliberately utilizes the language of change, strengths, and resources to help clients developing useful goals, recognizing exceptions, amplifying change efforts, and consolidating the new behaviors in their life. It becomes an open process in which the clients continuously make evaluations and choices. Ownership, options, and choices become an integral part of the treatment process (Lee et al., 2003).

Clinical Applications of Solution-Focused Brief Therapy

Solution-focused brief therapy has gained prominence in social work practice despite its relatively short history as compared to other established practice approaches in social work treatment. One plausible reason is that solution-focused brief therapy has its roots in social work because social work professionals actively participate in its development and dissemination. The late Insoo Kim Berg and Steve de Shazer, the founders of solution-focused brief therapy, were social work professionals. Peter de Jong, Michelle Weiner-Davis, and Eve Lipchik, who all belonged to the original group at BFTC, were social work professionals. Cynthia Franklin, Johnny Kim, and Michael Kelly applied solution-focused brief therapy to family practice and school social work (Franklin & Jordan, 1998; Kelly, Kim, & Franklin, 2008). Mo Yee Lee, Adriana Uken, and John Sebold are social work professionals who use solution-focused brief therapy to work with domestic violence offenders (Lee et al., 2003). Wally Gingerich, who conducted the first systematic narrative review of solution-focused brief therapy outcome studies, is a social work professional (Gingerich & Esiengart, 2000). This list is certainly not exhaustive as there are many other social work professionals actively applying solution-focused brief therapy with their client populations in creative and beneficial ways. Because the founders of solution-focused brief therapy were social work professionals, it is not surprising that the practice and value orientation of solution-focused brief therapy are consistent with the social work overarching framework of person-in-environment as well as the social work values of respecting clients’ dignity and self-determination (Karls, 2009; NASW, 1999). The practice of solution-focused brief therapy—being systems-based, collaborative, strengths-based, respectful, pragmatic, and focused—facilitates the adoption of this model by social work professionals in their work (Lee, 2011).

The increasing adoption of solution-focused brief therapy by social work professionals is plausibly related to its focus on clients’ strengths and resources, which is consistent with the empowerment-based and strengths-based approaches in human services; approaches that have gained increased prominence since the late 1990s (Rees, 1998; Saleebey, 2009). In addition, solution-focused brief therapy provides a specific set of treatment skills and

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techniques that help to operationalize strengths-based and empowerment-based practice in daily social work practice. In other words, solution-focused brief therapy translates the concept of strengths and empowerment to every day practice of using the “language of empowerment” (Rappaport, 1985; Rees, 1998) and the “lexicons of strengths” (Saleebey, 2008) in social work treatment. Finally, while the development of solution-focused brief therapy is entirely independent of the development of managed care, its emphasis on being brief, efficient, and effective clearly aligns with the mandate of managed care, which is on cost-effectiveness and cost-containment.

To date, solution-focused brief therapy has been adopted in a variety of social work practice settings (Nelson & Thomas, 2007). Examples of these settings or practices include but are not limited to the followings:

- Child welfare, for example, the Sign of Safety (Berg & Kelly, 2000; Turner, 2007)
- Family practice (Berg, 1994; Franklin & Jordan, 1998)
- Child and adolescent practice (for example, Berg, & Steiner, 2003; Selekman, 1993, 1997).
- Students from single-parent families and their parents (Lee & Grover-Ely, 2013)
- Schools (for example, Franklin & Gerlach, 2007; Kelly, Kim, & Franklin, 2008; Metcalf, 2008)
- Substance use (for example, Berg & Reuss, 1998; Smock & Trepper et al., 2008)
- Mental health (Knekt & Lindfors, et al., 2008A; Knekt & Lindfors, et al., 2008B; Macdonald, 2007)
- Domestic violence (Lee, 2007; Lee et al., 2003; Lee et al., 2012; Uken, Lee, & Sebold, 2013)
- Health (O’Connell & Palmer, 2003)
- Suicide prevention (Fiske, 2008; Hendon, 2008)
- Restorative justice (Walker & Hayashi, 2009)
- Administration and management (Lueger & Korn, 2006)
- Culturally competent practice (Lee, 2003; Kim, 2013)
- Coaching (for example, Berg & Szabo, 2005; Szabo & Meier, 2009)
- Supervision (Triantafyllou, 1997; Wheeler, 2007)

Relevant Research and Challenges

SFBT is gaining increased recognition as an evidence-based model. Solution-focused brief therapy is currently listed in the Office of Juvenile Justice and Delinquent Prevention Model Program Guide (<http://www.ojdp.gov/mpg/mpgProgramDetails.aspx?ID=712>) and is included in SAMHSA’s National Registry of Evidence-based Programs and Practices. In addition, Franklin and her associates published the book *Solution-focused brief therapy: A handbook of evidence based practice* (Franklin, Trepper, Gingerich, & McCullum, 2012). These are important milestones for solution-focused brief therapy, in part because the history of solution-focused brief therapy is relatively recent compared to other established treatment approaches such as cognitive-behavioral approaches. In addition, solution-focused brief therapy was developed by social work professionals in practice and not by academics at universities or research institutes. Nonetheless, the founders of solution-focused brief therapy, Insoo Kim Berg and Steve de Shazer, had a clear vision and support for advancing research in solution-focused brief therapy (de Shazer & Berg, 1997). At the EBTA conference at Brugge, Belgium, in 1997, t Berg facilitated a one-day post-conference meeting of people who were interested in solution-focused brief therapy research. This was probably the first “Research Day” to discuss research development in solution-focused brief therapy. The Solution-Focused Brief Therapy Association (SFBTA), which is the professional organization promoting solution-focused brief therapy in North America, continues its vision for promoting research of solution-focused brief therapy. The Research Committee of SBFTA is charged with the mission to promote, strengthen, and disseminate research pertaining to solution-focused brief therapy. This committee organizes a Research Day as part of the pre-conference activities. Since 2010, SFBTA has also funded the SFBTA Research Award, under the auspice of the Research Committee, to continue promote and support research in SFBT.

Outcome research.

Over the years, numerous intervention studies have been conducted for solution-focused brief therapy in diverse practice settings. Gingerich and Eisengart (2000) conducted the first systematic narrative review of solution-focused brief therapy outcome study. They conducted a systematic review of 15 outcome studies on solution-focused brief therapy. More recently, Johnny Kim has conducted a meta-analysis that consisted of outcome studies that were

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conducted between 1988 and 2005 (Kim, 2008). This review included 22 studies that used a control or comparison group in their study design. In addition, the meta-analysis focused on external behavioral outcomes, internal behavioral outcomes, and family or relationship problem outcomes. In addition, Corcoran and Pillai (2009) reviewed 10 studies that used SFT in treatment. The analysis of these studies found about 50% of the studies can be viewed as showing improvement over alternative conditions or no-treatment control.

While there is increasing empirical evidence of the effectiveness of solution-focused brief therapy, the rigor of these studies is limited by numerous issues in research design. These limitations, however, are not unusual in intervention studies conducted in real life practice settings. The identified problems include small and non-representative samples, lack of randomized controlled procedures, lack of specific manualized protocol, problems with treatment fidelity, measurement problems, and so on (Gingerich & Eisengart, 2000; Kim, 2008; Lee et al., 2007). To further develop and strengthen evidence for the efficacy of solution-focused brief therapy, future studies should consider a more rigorous research design that (1) uses larger and more representative samples; (2) includes control or comparison groups using randomized assignment procedures; (3) uses standardized measures that are sensitive enough to measure treatment changes; (4) uses observation-based rating systems in data collection when possible and appropriate, (5) further refines and develops the treatment manual for training purposes and fidelity analyses, (6) increases the rigor of the fidelity procedures by using observation-based approaches with a refined, specific, and rigorous fidelity measurement protocol; (7) carefully monitors the data collection process to reduce problems in measurement attrition; and (8) includes research sites that serve ethnically and racially diverse populations (Lee, 2011).

Process research.

A unique development in solution-focused brief therapy research is its incorporation of microanalysis as a major research effort. Microanalysis is the close examination of moment-by-moment, utterance-by-utterance communicative actions in conversations, with an emphasis on how these sequences function in the interaction (Bavelas, McGee, Phillips, & Routledge, 2000). Microanalysis views communication as constructive and directive (Bavelas, Coates, & Johnson, 2000). Consequently, microanalysis as a research method allows us to closely examine the co-constructive process in treatment, which is a hallmark of solution-focused brief therapy. A group of researchers led by Janet Bavelas that includes Peter de Jong, Harry Korman, Sara Smock, Adam Froerer, Christine Tomori, and Sara Healing are using microanalysis to study therapeutic communication as a mechanism of change in solution-focused brief therapy. Their work includes the following types of research: (1) process research (for example, microanalysis of communication within therapy sessions) that assesses congruence between theory and practice and reveals similarities and differences in therapeutic approaches (De Jong & Bavelas, 2009; Froerer & Smock, 2009; Tomori & Bavelas, 2007), and the communication process such as formulation and grounding sequences in treatment (Bavelas, 2011); (2) basic experiments in a laboratory setting that provide evidence supporting fundamental assumptions such as co-construction in the treatment process (for example, Bavelas et al., 2000; 2002); and (3) experiments on therapeutic techniques, which test key techniques such as the miracle question in the laboratory using non-therapeutic tasks and populations (Healing & Bavelas, 2009). Such research program illuminates important mechanisms of change and other process issues involved in the solution-focused treatment process. In addition, microanalysis in itself introduces novel research methodologies in understanding the therapeutic processes that may be relevant to other types of social work treatment approaches.

The Future

Each social work treatment approach makes different assumptions about how problems of living should be approached as well as how change happens. Recognizing the power of therapeutic dialogues and the potentially harmful effects of a pathology-based and deficits-based perspective in sustaining the problem and disempowering clients, solution-focused brief therapy deliberately adopts the language and symbols of “solution and strengths” and fully embraces clients’ voices and resources in the search for effective solutions. While doing so, it is important to evaluate the effectiveness of solution-focused brief therapy and carefully examine the associated mechanisms and processes that contribute to its effectiveness so that treatment is based on an informed position in addition to ethical choices or theoretical preferences (Lee, 2007).

Another challenge in the development of solution-focused brief therapy is the dilemma between fidelity adherence

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versus open flow. Solution-focused brief therapy emphasizes itself as a way of thinking and not just a set of techniques (de Shazer, 1985). The treatment process is a co-constructive process between the solution-focused practitioner and the client. Consequently, there are questions about how much the professional body, that is, SFBTA, can and should ensure strict fidelity to an “established” treatment protocol. If this is not feasible or desirable, how can we develop some structure (such as a national network of basic solution-focused brief therapy training), establish defining parameters, or the minimum amount of SF to ensure the adherence to the model (personal communication with Gallagher & Nelson, 2012).

Albeit these challenges, helping professionals around the globe are practicing solution-focused brief therapy in a variety of settings with diverse client groups in beneficial ways.

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Further Readings

European Brief Therapy Association: <http://blog.ebta.nu/>

Solution-focused Brief Therapy Association: <http://www.sfbta.org/>

Solution-Focused Brief Therapy Evaluation List: <http://www.solutionsdoc.co.uk/sft.html>

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