

# Solution-Focused Brief Therapy With Long-Term Problems

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## Introduction

Solution-Focused Brief Therapy (SFBT) was originally developed in 1982 by Insoo Kim Berg, Steve de Shazer and their colleagues at the Brief Family Therapy Center in Milwaukee, Wisconsin. Initially, they had applied the problem-resolution approach that they had learned working with John Weakland at the Mental Research Institute in Palo Alto, California.<sup>1,2</sup> However, as they listened to clients describing the details of a problem, they began to notice that clients also described exceptions, times when a problem was either absent or minimal. At this point, the focus of the therapy shifted from the description of the problem to details of to exceptions. It was this shift that moved the therapy from problem resolution to solution development. As the focus of therapy became redefined, the respective role expectations of the therapists and the clients shifted as well. These solution-focused therapists viewed clients as experts on their lives and, more importantly, what will be useful to them. SFBT can thus be defined as a client centered and collaborative process.<sup>3</sup>

As therapy becomes redefined, the assumptions we make about the process, the therapist and the client inevitably change too. We begin to view diagnosis from a different perspective. Solution-focused therapists tend to be curious about the individual and his/her social context, resources and future visions. Clients who have been involved in the mental health system for years have been defined and have come to define themselves by their limitations. As a result of working with mental health professionals over many years most not only know their diagnosis but in fact have come to learn how to *be* their diagnosis. Solution-focused therapists

are interested in what people do to make their lives better, not in how their diagnoses or their problems limit them. In practice, therefore, SFBT seeks to expand individual possibilities.

### **Basic Approaches of SFBT**

Solution Focused Therapy challenges the assumptions of conventional theories of psychotherapy. As the original assumptions were questioned and to a large extent, abandoned, new assumptions replaced them.

#### **Basic Assumptions:**

The set of assumptions that inform solution-focused practice:

1. **Change is constant and inevitable;**
2. **Small changes result in bigger changes;**
3. **Since you can't change the past, concentrate on the future;**
4. **People have the resources necessary to help themselves: they are the experts;**
5. **Every human being, relationship and situation is unique;**
6. **Everything is interconnected;**
7. **Every problem has at least one exception;**
8. **Therapy is not the only way people change, there are many things that are therapeutic (p. 79).**

The application of these assumptions redefines therapy in many different ways. The therapist/client relationship is de-emphasized. Instead, the focus is on what clients do outside of the therapy office that is helpful and moves them toward realizing their goals for therapy. Thus, instead of "talking about living a life," we focus on "living a life." As opposed to the medical model that assumes that problems are within the individual, SFBT contextualizes solutions socially. **Solutions arise from the individual's social context and as a result of personal and**

**social resources.** This way of thinking offers more flexibility in developing solutions.

Many clients experience their problems as the *status quo*. Our experience tells us that *status quo* is illusionary and that exceptions are already happening. A study done by Weiner-Davis, de Shazer and Gingerich<sup>5</sup> surveyed 30 clients and found that 66% reported positive, pretreatment change. In describing this study, Miller and colleagues<sup>11</sup> state:

*. . . The studies conducted to date clearly indicate that beneficial change can and frequently does occur prior to the initiation of formal treatment. For example, change due to the operation of chance events or client strengths may be partly responsible for approximately 40% of clients who improve enough not to need treatment on a waiting list for services. pp.42*

It becomes the therapist's job to redirect the client's attention to useful exceptions.

#### **Brief Versus Short Term**

Solution-focused therapy is a brief approach. There is often confusion between short-term and brief therapy and often the terms are used interchangeably. Conceptually, they are very different.<sup>6</sup> In general, short-term therapy uses time as a motivator of progress. In short-term therapy, there is a specific time frame, usually expressed in the total number of sessions. The short term therapist will explain to the client that he or she has a certain number of session, days or weeks in which to do the necessary work.

Brief therapy is focused on goals. The therapist works with clients to define specific goals and once they are well on their way to accomplishing their goals, therapy is, by definition, completed. Steve de Shazer, in the introduction to Yvonne Dolan's book,<sup>7</sup> states, "'Brief therapy' simply means therapy that takes as few sessions as possible, not even one more than is necessary, for you to develop a satisfactory solution" (p. x).

#### **The First Solution-Focused Session:**

There are two functions that are accomplished simultaneously in the first solution-focused session: development of an initial goal and initiation of the solution building process. As previously stated, well-defined goals are keys not only for keeping therapy brief, but also to ensure a

successful outcome. Insoo Kim Berg and Scott Miller<sup>8</sup> detail seven qualities comprising well-formed goals:

1. **Saliency to the Client**
  2. **Small**
  3. **Concrete, Specific and Behavioral**
  4. **The Presence Rather than the Absence of Something**
  5. **A Beginning Rather Than an End**
  6. **Realistic and Achievable Within the Context of the Client's Life**
  7. **Perceived as Involving "Hard Work"**
- (pp. 32-43).

### **The Six Questions**

The questions that the therapist uses to negotiate the goal with the client simultaneously help move the client into a solution-building process.

Solution-focused therapists use six questions that have been developed collaboratively with clients.<sup>9</sup> We have found it helpful to ask the client about pre-session change.<sup>3,8,9</sup> For example, we might ask, "Between the time you called to set up this appointment and today, what is it that you've noticed that is already a little bit better?"

Research data<sup>5</sup> suggests that a high percentage of clients will answer pre-session change questions substantively.

When a client is able to provide details of pre-session improvement, it facilitates solution-building in several ways. First, it provides the therapist and client with clues of the goal. There is high probability that the client need only to continue and increase what is already happening. Second, it moves the conversation from the exploration of the problem to the building of a solution. We've found that when clients begin to perceive expanded possibilities, they more quickly

begin to develop useful solutions. Pre-session change questions move the client in that direction of possibilities and goals simply and effectively.

If clients are unable to delineate pre-session change, or are unclear about how they will know that their problem is solved, we will usually ask them about their vision of a better future,<sup>3,8,9</sup> the second type of useful question. Asking an individual about the details of how things will be better including how others in the social environment will notice the improvement, is an effective way of helping the client begin constructing a solution picture. For example, we might ask, "Suppose, your meeting with me today is helpful. What will be the first sign to you that things are different?"

Once the client begins to develop a solution picture, solution-focused therapists then ask the Miracle Question:<sup>7</sup>

*Suppose that one night (pause), while you are asleep, there is a miracle and the problem that brought you into therapy is solved (pause). However, because you are asleep you don't know that the miracle has already happened (pause). When you wake up in the morning, what will be different that will tell you that the miracle has taken place? What else? (p. 13).*

The Miracle Question was developed at the Brief Family Therapy Center in 1983 and actually suggested by a client to Insoo Kim Berg. It continues and expands upon the solution picture. More importantly, it minimizes "problem talk." Steve de Shazer<sup>1</sup> addresses this point,

*All the miracle question is designed to do is to allow clients to describe what it is they want out of therapy without having to concern themselves with the problem and the traditional assumptions that the solution is somehow connected with understanding and eliminating the problem (p. 273).*

The immediate visible reaction by clients to the miracle question is that they sit back in the chair and become thoughtful and relaxed. The therapist needs to allow clients a considerable amount of silence for introspection since this is a

new experience for most of them. Even with careful pacing and connecting with clients, the common immediate response frequently begins with, “I don’t know. . . I suppose, I will be calmer, relaxed . . . like I could face the day. . .” It is important to track the client’s solution picture in detail.

In the course of asking solution-building questions, quite often the client will raise exceptions, times that the problem either is experienced as less significant or absent entirely. When the therapist hears this, it is usually helpful to expand on exceptions.<sup>3,8,9</sup> In the course of discussing the Miracle Question, solution-focused therapists might ask the client about exceptions directly. For example, “What part of the miracle is already happening?”

Once the client details his or her miracle picture, the solution-focused therapist will ask a Scaling Question.<sup>3,8,9</sup> Scaling Questions not only help the client to recognize exceptions, but begin the process of defining the “next steps.” The typical scaling question requests the person to place oneself on a scale from 0 to 10, where 0 is the least desired condition, and 10 is the most desired outcome. Scaling possibilities are unlimited and many different types of scales can be used: for example, miracle day scales, confidence scales, motivation scales, or even safety scales. Scaling possibilities are limited only by the therapist’s creativity and the applicability to the client.

When using scales, the solution-focused therapist will discuss what the particular number means to the client. The question is always in terms of how the client got up to the number on the scale rather than why the number is not higher. For example, if a client tells us that he or she is at 3 on the scale, we might ask, “How is 3 different from 0,” or, “How did you go all the way up to 3?”

After the meaning of the specific scale number is negotiated, the solution-focused therapist will then ask how the client will know when he or she is just one number higher on the scale. This next step is discussed in detail; we want to know what will be different for the client and how other people will know when the next step is reached. We also ask what difference that

next step will make for the client as well as others within his or her social environment.

Pre-session, vision of the future, miracle, exception and scaling questions will be useful with the majority of clients. Occasionally, a client may have initial difficulty thinking beyond the problem situation and is unable to shift into a solution-building context. At these times, we find it useful to ask clients *coping questions*.<sup>3,8,9</sup> For example, “Given everything you have told me about what’s going on in your life, how do you just make it through each day?” We find that most often the client will respond with a strength based response. The solution-focused therapist can then expand on that response. For example, in response to a coping question the client might say, “My mother taught me how to be strong.” The therapist would respond, “What would your mother see you doing now that would tell her that you’re being strong?”

As solution-focused therapists, we employ the six questions appropriately in order to gauge the client’s response. To be truly helpful to the client, the therapist must practice careful listening. We find it most helpful to weave our next questions in response to the client’s key words. For example, when a client says, “I won’t be ashamed of myself anymore,” we might use the client’s key words and ask, “So, when you are no longer ashamed, what would you feel instead?” As the therapist develops listening skills to facilitate this kind of conversation, he or she begins to become aware of a wealth of possibilities, each one having the potential of moving the session in useful ways. The therapist needs to really *listen* to what the client says and not assume anything.

At this point in the session, the therapist will take a break. If working with a group of colleagues behind a one-way mirror or video monitor, the therapist will discuss the client. If working alone, he or she will take time to think about what the client said during the interview. When the session resumes, the therapist will relate what he or she and/or the team thinks. Campbell, Elder, Gallagher, Simon, and Taylor<sup>10</sup> characterize the message as compliments. The authors summarize this compliment process:

*The compliments usually include validation of concerns, recognition of*

*competencies, and a suggestion for something to do between sessions (pp. 3-4).*

Between-session suggestions are designed appropriate to the client's motivation for change.<sup>11</sup> For example, for clients who are highly motivated, we might suggest they choose 2 or 3 nonconsecutive days during which they act as if the miracle had happened. Those clients who are less motivated might be asked to report on what they noticed has moved them up one point on the scale. Those clients who are referred by a third party (e.g., a probation officer, Department of Social Services, or Child Protective Services) and who have no clearly defined goals are not often given between-session suggestions. The attempt in any between-session suggestion is to match the suggestion to the client's motivation to insure a higher probability of completion.<sup>11</sup>

### **Subsequent Solution-Focused Sessions:**

Scheduling of subsequent sessions is decided at the end of each session. This is different from the traditional custom of scheduling weekly sessions. Clients will make the decision of when *they* want to return, and most choose to wait 2 or 3 weeks. In addressing return visits, the therapist's interest is that the client has enough time to think about and use the between-session suggestion.

We have found it helpful to begin subsequent sessions with a scale. The session is then naturally built around signs of progress and possible next steps. Berg and DeJong<sup>3</sup> present a useful way of expanding on the solution-building process in subsequent sessions:

*Insoo and her colleagues at BFTC have spent many years working out new and more effective ways to do this. They have developed the acronym EARS to capture the interviewer's activities in this work. E stand for eliciting the exception. A refers amplifying it, first by asking the client to describe what is different between the exception time and problem times and second by exploring how the exception*

*happened. . . R involves reinforcing the successes and strengths that the exception represents. . . Lastly, the S reminds interviewers to start again, by asking, "And what else is better?" (pp. 136-137).*

## **Application of Solution-Focused Therapy**

The strengths of the solution-focused approach are its flexibility and adaptability. If one question does not prove particularly useful, most likely another will be worth the therapist's attention. Since there are unlimited ways that solution-focused therapists have of asking the six useful questions, the approach can be adapted to a diverse clientele. Following is a case presentation which will demonstrate the approach's usefulness with an individual who has spent many years using community mental health services.

### **Case Example:**

#### ***Client Background***

Steven is 40 years old. According to the record, he has had a history of psychiatric problems from early childhood. His first hospitalization was at the state psychiatric center at age 17. Since then he has had multiple hospitalizations in community hospital mental health units as well as the state psychiatric center. The average hospital stays were of relatively long duration lasting from 3 to 8 weeks. There are 4 psychiatric evaluations, completed by separate psychiatrists, that represent the past 6 years. Each of those psychiatrists has diagnosed Steven as schizophrenic, undifferentiated type, and chronic. During the course of his years in mental health, he has been on a variety of psychiatric medications, many of which he complained produced side effects.

Steven was referred to Community Counseling at Goshen in May 1996 by another outpatient, community mental health clinic. Several weeks prior to his referral, the psychiatrist had written:

*Patient complains of swollen tongue. Will discontinue [the medication]. Moreover he has been giving variable complaints, verbalizing suicidal ideation, then retracting it. Now complains of insomnia. I believe he is malingering for attention.*

This final psychiatric note was filed:

*Steven, as is usual, now requests a return to [name of medication] several weeks after he requested to have [same medication] changed as ineffective. Things are going round and round with no progress. His family reports that he lies and should not be believed. This however leaves open the question of how to track him. . .*

### **Solution-Focused Brief Therapy Treatment Process**

Steven was first seen at Community Counseling at Goshen in mid-June 1996. The therapist is Joel Simon. All therapy sessions used a one-way mirror and a consultation team. The following process summary represents approximately 30 sessions over the course of 2 years. Each session lasted approximately 1 hour, and the average length of time between sessions was 3 weeks.

Initially Steven was asked what he wanted from coming to therapy. He responded that he wanted to “get help with schizophrenia.” When asked how he would know that he was getting that help, he said that he would be more outspoken with people. This was expanded on when the Miracle Question was asked.

During the course of the miracle question, Steven spoke about what was already helpful to him in his life. He said that his current medication helps to prevent hallucinations. When he was asked how he helps the medication to work, Steven presented a wide variety of helpful activities: taking long walks, praying, and being with his friends and family.

Steven was then asked to scale himself where 10 is being on track, and 0 the opposite. He responded that he was at 10. When asked to assess himself on a scale where 10 is not needing

therapy to continue this progress, and 0 is needing therapy, he responded that he was at 0.

After the break, the team had many compliments for Steven, including his hard and his knowledge of what is helpful to him. They suggested that he take notice of what he does that keeps him on track.

Steven returned 4 weeks later, still reporting that he was on track. He reported that he was calmer and his family was noticing this. He continued to do those things that he previously reported as helpful. Once again, he gave much credit to the medications he was taking. The therapist asked him what percent of his success was due to the medications and what percent his hard work? Steven responded that 10% was the medication and 90% was his work. Steven expressed an interest in returning to a work program that had not been successful for him previously. The team validated his hard work and expressed how impressed they were about the program that he has developed for himself to stay on track. They suggested that he take notice of what shows him that he’s ready for the work program.

Steven returned 1 month later and reported that his father, who had been very ill with cancer, died during this period. When the therapist asked Steven what he had been doing that was helpful in dealing with his father’s death, he reported that his friends and family had been supportive. He felt better and had reached some of his goals before coming to the counseling center this time. He said again that he is ready to return to the work program and explained what he noticed that told him that he was ready to return.

During the course of the next few sessions, Steven met with staff from the work program and presented to them in an articulate and logical manner, why he felt he was ready to return to the program. Unfortunately, because of their previous negative experience with him, they turned him down. He was understandably disappointed but was willing to accept an alternative training program.

In the next several months, Steven attended the job-training program regularly and the supervisor reported that he was on time and responsible. Steven opted not to go into the next phase of the training and instead decided to attend a psychosocial club (River Club) close to where

he lives. He was able to provide an intelligent rationale for his decision.

As of this writing, Steven continues to attend the program, has made many friends, and speaks with excitement of his experiences there. Recently, he has become involved in a job-training program associated with the club. He has wisely built a network of social supports that includes his family, his church and the staff and members of River Club.

Steven experienced several important events during the course of his work with solution-focused therapy. His father, with whom he was very close, died in late 1996. Steven signed himself into a local community hospital mental health unit in December 1996. He stated that he was feeling depressed since As previously stated, during the past two years, Steven's total hospital days had decreased dramatically to a day and a half. This despite several major life stressors: the death of his father, the death of his mother, change of residence, being denied a job training program, and having to cope with a minor legal situation (he was arrested for harassment).

### **Building Solutions**

In November 97, Steven reported that he talked to his psychiatrist about having auditory hallucinations. The psychiatrist suggested he discuss this with his therapist. Following is an example of how solution-focused therapists use questions in the solution-building manner. Notice how the therapist is selective about what he pays attention to, what he does not, and how he phrases questions.

In the course of introducing the topic, Steven said, "It happens most of the day. When I go to River Club, I don't hear it."

Therapist: *So when you're at River Club, you don't hear it.*

Steven: *When I'm here, I don't hear it either.*

Therapist: *What's different at River Club, what's different here?*

Steven: *I also don't hear it in church.*

Therapist: *So what's different here, River Club and church?*

Steven: *At River Club there's noise that blocks it out. Same thing in church. When I'm alone I hear it-it's scary. I asked my mom whether she hears it. She told it's probably in my mind.*

Therapist: *What told you to ask your mom? That's impressive! You did an experiment-you did some research.*

Steven: *(Laughs) Yeah, I asked my mom.*

Therapist: *How did you figure out how to do that?*

Steven: *I wanted to make sure it wasn't something going on in the whole family. My sister said she didn't hear it, my mom said she didn't hear it.*

Therapist: *Once you found out it wasn't real, how did that change things for you?*

Steven: *It's still kind of scary. I know it's not real.*

Therapist: *That's helpful?*

Steven: *It helps relieve some of the scariness.*

Therapist: *What other times at your house you don't hear it?*

Steven: *I don't hear it during the day, only at night.*

Therapist: *What's different during the day?*

Steven: *During the day, I'm busy. My mind is on other things.*

Therapist: *So, when you're busy, your mind is on other things*

Steven: *Only when I'm by myself and alone, I hear it.*

Therapist: *If I had a scale where 10 is it only happens at night. It's really not scary and you can ignore it and 0 is the opposite, where would you put yourself right now?*

Steven: *I'd say 5. I control it a little bit, not much.*

Therapist: *How do you control it?*

Steven: *Take my medicine on time. Eat right-I'm diabetic. That has something to do with it.*

Therapist: *How's the medicine help?*

Steven: *Which one? For diabetes or my Schizophrenia?*

Therapist: *Either one.*

Steven: *It stabilizes me; keeps me calm and I sleep well.*

Therapist: *And controlling your diet, how is that helpful?*

Steven: *If I eat well. . . If I drink coffee, I hear it more. So I cut down on coffee.*

Therapist: *What else gets you to 5?*

Steven: *I pray a lot, that helps. I talk to people. When I get angry, I hear it even more.*

Therapist: *So, how do you keep from getting angry?*

Steven: *Go to River Club and talk to people there.*

Therapist: *Since you've been doing that and getting less angry, what have you noticed is different?*

Steven: *I haven't been hearing it as much.*

Therapist: *What else do you do to get to that 5?*

Steven: *Look at my [car] models; sometimes I draw. I go to the library.*

Therapist: *How are those things helpful?*

Steven: *They help pretty good.*

Therapist: *How would you know that six is happening?*

Steven: *Keeping more active and controlling it more.*

Therapist: *What about at night, how would you know 6 is happening then?*

Steven: *Probably keeping busier-finding something to do to keep busy.*

Therapist: *What could you do that would be helpful?*

Steven: *Call a friend I could trust.*

Therapist: *What else?*

Steven: *Exercise, do sit ups. Read the Bible or books.*

Therapist: *So, on a confidence scale where 10 is you're really sure that these things will help and 0 is the opposite, where are you?*

Steven: *10. The other thing is going to bed later.*

Therapist: *You have lots of good ideas. How did you come up with them?*



Steven: *That was what my dad said to do.*

Therapist: *What other ideas did Dad have that are helpful to you?*

Steven: *He said don't think too much. Don't sit around and daydream. Stay busy.*

At this point, I asked Steven to scale himself on an "on track" scale where 10 is on track and 0 is the opposite. He scaled himself at 10.

## Restructuring

Campbell, et. al.<sup>9</sup> write about restructuring:

*Many clients have defined the problem in ways that limit solutions, e.g. chemical imbalance, abusive partners, misbehaving children or a diagnostic label. Solution-focused therapy uses questions to create awareness of options. Restructuring statements are effective tools in this process. . . While the team offers possible options for thinking differently, it is the client who actively restructures his or her own thinking (p. 7).*

The authors further clarify the definition of restructuring:

*Our use of this word is not related to a belief in a deeper psychic structure, but rather to how clients come to think differently about themselves and their problems (p. 7).*

We have found that clients who have been treated in conventional mental health services for many years, define themselves in ways that limit options. For example, they are told that they have an illness which needs to be managed, similar to diabetes. They need to maintain a minimum of stress, and to have "realistic" aspirations for themselves.

In one particular poignant session, Steven spoke of his diagnosis, stating that he has an illness and knows that he is schizophrenic. Steve de Shazer<sup>1</sup> writes about this issue:

*"Schizophrenia" started out as the name of a concept and subsequently has become reified and thus is frequently read or interpreted as static, as not changing over time. The term is usually read to mean that cure is impossible: Only remission is possible and therefore relapse is always lurking around the corner (p. 108).*

Solution-focused therapy co-constructs possibilities with the client. Diagnoses, especially diagnoses such as "schizophrenia," imply disability. Solution-focused therapy focuses on what clients do to improve their situation.

When the therapist had returned from consulting with the team, he said the following to Steven:

Therapist: *Well, we certainly had a lively discussion back there, Steven. I think the first thing we want to say is the only use we find in any diagnosis is that it gets us paid. We've worked with you a long time and have been impressed with how you think, how you've figured out how to make your life better and keep yourself on track. We don't see you as your diagnosis. We just see you as Steven.*

Steven: *That's the first time anyone ever said that to me.*

It's obvious from this brief excerpt to see how years in the conventional mental health system have served to, using de Shazer's language, reify the diagnosis for Steven. As the sessions went by, Steven began to talk differently about himself; he began to report being able to see the normal things that he does. In one particular session Steven said, "I say I have more of a sound mind now." Significantly, those who had known Steven for many years, those in varied mental health

professional roles and his family, began to comment on the positive differences they were seeing.

In April, 1998, Steven decided that he no longer needed to continue in therapy. As is the custom in Community Counseling at Goshen, Steven participated in a discharge interview:

Interviewer: *What happened here that was helpful to you?*

Steven: *I first started coming June 17, 1996. As soon as I started coming here, I started doing better. In the other therapy, they started getting too personal. I like coming here.*

Interviewer: *Is there anything we missed or could have done better?*

Steven: *No, everything was just right.*

Interviewer: *Now's your chance to scale [the therapist]. On a scale of zero to ten, where would you put him?*

Steven: *10*

Interviewer: *What put him there?*

Steven: *The way he expressed things. He helped me understand better.*

Interviewer: *If a friend or family member asked you to describe what happened here, what would you tell them?*

Steven: *When I first started coming, I was nervous. But, after a couple of weeks, started feeling really different. It helped out really good. They really helped me here.*

Interviewer: *Any other comments?*

Steven: *I made a lot of progress over the past two years.*

Steven's case demonstrates that the solution-focused brief therapy approach will work with clients who have had long time involvement in the mental health system. In reviewing Steven's progress for this lesson, the authors become very aware of the simple yet powerfully effective assumptions that guided the therapy. The therapist worked from the assumption of Steven's competencies. The questions the therapist asked focused the client on the strategies and resources that he was developing during the course of their contacts. In general, the therapist's interest was in what Steven was doing in between sessions that was helpful to him.

Through the course of the therapy, Steven increasingly experienced his own empowerment. The therapy served simply to affirm the progress that had become more and more evident. What may in fact be the most helpful to our clients is working with therapists who know less and are willing to discover more about their patients. As solution-focused therapists, we have become increasingly curious about our clients' strengths and resources. Careful listening driven by this curiosity and desire to discover more about our clients ultimately is most helpful to them.

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## **Conclusion**

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