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THE INTEGRATION OF EMOTION IN SOLUTION-FOCUSED THERAPY

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The authors believe that solution-focused therapy can be enhanced by more overtly incorporating emotions into its theoretical framework and therapeutic strategies. They discuss the role of emotions in solution-focused therapy and offer several solution-focused interventions that utilize client affect.

Solution-focused therapy is a growing force and the preferred orientation for many family therapists. In an expanding array of books and articles, solution-focused therapy is described and contrasted with other forms of therapy (e.g., de Shazer, 1982, 1985, 1988; de Shazer et al., 1986; Molnar & de Shazer, 1987; O'Hanlon, 1988; O'Hanlon & Weiner-Davis, 1989). Its brief, nonpathological approach and utilization of clients' inner resources appear consistent with a wide variety of other contemporary family therapies (Hoffman, 1990; O'Hanlon & Weiner-Davis, 1989; White & Epston, 1990).

The solution-focused therapist's primary goal is to construct solutions in collaboration with the client. Typically, the therapist begins in the present, trying to understand and join with the client's view of the problem. Further exploration to describe what the client and his/her family are *doing* differently when the problem does not happen helps to clarify clients' goals. Scaling questions (e.g., "On a 10-point scale, how depressed were you today?" and "What will you be doing differently when you are at a 4 instead of a 3?") help both therapist and client gain a more concrete perception of the problem and possible solution. Tasks are given to clients to reinforce the times exceptions occur (de Shazer et al., 1986; Lipchik, 1988a, 1988b; Lipchik & de Shazer, 1986). Emphasis is on what each client is already doing that is useful. Thus, client strengths are emphasized in this therapy.

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The Role of Emotion in Solution-Focused Therapy

The role of emotion in solution-focused therapy has been neglected. Instead, solution-focused therapists have primarily concentrated on the cognitions and behaviors of their clients. We believe that, since emotions are central to the lives of all people, the theory and practice of solution-focused therapy can be enhanced by both examining and extending the place of emotions in this model. We also believe that skilled solution-focused therapists are already employing emotion in largely unacknowledged ways. It would be useful both to highlight the current role of emotion in solution-focused interactions and more overtly to incorporate emotions into solution-focused strategies. These are the purposes of the present paper.

CONCEPTUAL FRAMEWORK FOR INTEGRATION

All family therapies direct clients to attend to particular information. They structure therapeutic dialogues, either directly or indirectly, in such a way that clients become aware of processes that impede or encourage the resolution of their problem. Typically, solution-focused therapists, in asking about exceptions to problems, direct clients to attend to both internal cognitive processes and external behaviors. Generally, they shift the client's focus from emotions to observable behaviors that accompany them (e.g., "When you are feeling happy together, what are you doing?"). We believe that much more can and should be done to highlight and directly integrate affect into solution-focused techniques.

Emotional Development

Current research (e.g., Brazelton, 1983; Kellerman, 1983; Plutchik, 1990; Shaffer, 1989) indicates that emotional development begins very early in life. Although emotions are shaped by our environment, they also have a biological, genetic base (Fuller, 1986; Greenberg & Safran, 1990; Maturana & Varela, 1988; Plutchik, 1990). According to Plutchik (1983), many emotions are based on genetic templates or schemata that determine emotional development and emotional responsiveness to others. Plutchik (1990) further postulates that along with cognitions and behaviors, emotions form complex chains of events that, in response to relating with others, result over time in homeostatic, predictable patterns.

Emotions require that the person who has them maintain a state of internal awareness (Plutchik, 1980, 1984). Others who have personal knowledge of an individual, including his or her history, and can observe the person's behavior may be sufficiently intuitive to infer that individual's emotions. Clearly, one's experience and interpretation of emotions are related to one's social context (Averill, 1980, 1982). Emotions are also a product of repeated interactions between an individual and her/his environment.

Such a viewpoint is consistent with the constructivist nature of solution-focused therapy. Constructivists believe that our awareness of the world is a direct result of our active interaction with it. We never see the world directly, only through the lens of our own perceptions. Reality, so to speak, is in the eye of the beholder (Efran, Lukens, & Lukens, 1988).

The Relationship of Emotions, Cognitions, and Behaviors

Current research and theory conceptualizes emotions, cognitions, and behaviors as complementary and interrelated. Thus, they are seen as intrinsically intertwined, each altering and informing the other (Bower, 1981; Greenberg & Safran, 1984; Hahlweg, Baucom, & Markman, 1988; Jacobson, 1984; Leventhal, 1984; Plutchik, 1990). The fact that various

authors and schools of family therapy have separated emotion, cognition, and behavior (and have emphasized one over another) is more a matter of conceptualization than reality (Greenberg & Johnson, 1988).

Emotions, as defined here, are consistent with Arnold's (1960) notion of the concept. That is, emotions are intuitive appraisals that initiate action tendencies in individuals. Emotions provide impulses to act in certain ways, while corresponding cognitive processes determine whether or not impulses will be acted upon (Greenberg & Safran, 1987, 1990; Izard, 1977).

According to Greenberg and Safran (1987), people have "learned to avoid their emotions and often need permission to feel" (p. 188). Moreover, mutual self-disclosure and acceptance of each other's feelings, especially those of vulnerability, tend to result in less defensiveness and more positive responses from one's partner (Greenberg & Johnson, 1988).

Resistance to Focusing on Solutions

Some clients have difficulty identifying exceptions to their problem or imagining the future when the problem is solved. This may be because automatic, strong emotions cloud their ability to recall occasions when the problem did not occur or when they were coping satisfactorily (Bower, 1981).

Affective states have been found to have powerful influences over cognitive processes (Bower, 1981; Greenberg & Safran, 1984, 1990). For example, a solution-focused therapist might ask: "Is there a time when the complaint does not occur, or occurs a little less often than other times?" "How will we know when you don't need to come to therapy any more?" or "If a miracle were to occur tonight and in the morning your problem is solved, what will be different?" Such questions ask clients to think about those times that solution patterns happen, as opposed to problem patterns. They evoke a shift to the person's more positive affective state. However, strong negative emotions may make such questions difficult to answer. The movement in solution-focused therapy from problems to solutions is not automatic. It involves considerable therapeutic skill to help a client move from "affective congruence" (feeling bad and talking about negative experiences) to "affective incongruence" (feeling bad and shifting focus to more positive emotions) (Bower, 1981).

At times, clients' reluctance to imagine a future time when the problem is partially or completely resolved may be an effort on their part to protect themselves from the consequences of change (Fisch, Weakland, & Segal, 1982) or from getting their hopes up when they believe disappointment will follow. They may conclude that if they do not imagine things being better they will avoid the eventual pain and disappointment of not reaching their goals. The "solutions" underlying such negative emotions as hopelessness and fear need to be actively explored and perhaps challenged by the solution-focused therapist.

De Shazer (1985) believes that it is important to "fit" therapeutic intervention to (a) client behaviors, (b) the context in which behaviors occur, (c) the meanings attached to behaviors or contexts, and/or (d) the more general world view of the client. We believe that it makes sense for the solution-focused therapist to extend her or his notion of fit to include the client's emotions. We also believe that it is important for the therapist to appreciate the power of emotions in supporting both stability and growth, and to learn how better to use client affect in the change process.

Joining with Negative Affect

Many skilled solution-focused therapists have developed ingenious ways both to join with and transform negative affect. Initially, they may look for exceptions to negative feelings by asking about (a) presession changes (Weiner-Davis, de Shazer, & Gingerich, 1987), (b) exceptions to problems, and (c) hypothetical exceptions (Lipchik, 1988a). When clients do not respond to the therapist's attempt to help them see positive differences, some solution-focused therapists may attempt to elicit responses by asking about negative differences (e.g., "Why are things not worse?" or "How will things be different when they are at their worst?") (Lipchik, 1988b). When clients are asked to imagine disastrous events (which parallels the paradoxical intervention known as "positioning"), they often respond with a resolve not to have those events occur. Such responses as, "I'd never let it get that bad. I love my children, and don't want to see them hurt," are exceptions to a worst case scenario that can be built upon in therapy to construct solutions.

Similarly, if clients are unable to allow even a small positive refocus, solution-focused therapists may decide to join more earnestly with their negative frames or affective states. As above, sequences of questions which join with clients' negative emotions may paradoxically provide a context for the client to recoil and take constructive action. Family members may realize that they need to do something different so that things do not get as bad as they are imagining. A possible questioning sequence might be: "Things certainly appear to be going from bad to worse. Do you think they have hit rock bottom yet? What do you imagine things will be like at their worst? How much worse do you think they will get? What will you do when that happens?" (Lipchik, 1988b, p. 136). Often, clients will give examples of why things are not that bad, which gives the therapist something positive with which to work (Lipchik, 1988b).

Eliciting Positive Feelings

The solution-focused therapist can evoke positive emotions by helping clients recognize positive and desirable emotional states or interactional patterns. This can be done, for example, by helping clients recognize those times when desired feeling states (and accompanying thoughts and behaviors) have already occurred (i.e., exceptions). It is also possible to help clients become aware of new feelings toward themselves and/or others which might lead to different, more satisfying interactional patterns. For example, consider this modified form of the miracle question (de Shazer, 1988):

> Suppose that one night, while you were asleep, there was a miracle and this problem was solved. How would you know? Would you feel different? How could you let your husband know that you are feeling this way?

Similarly, here is a "soft" challenging intervention intended to tie a positive feeling state of one partner to a more appropriate behavior response from the other:

> The team challenges each of you this week to do something to make the other feel better about your relationship. Your challenge this week is to "have your antenna up" to figure out what it is that your partner did.

In addition, solution-focused therapists, like behavioral therapists (e.g., Jacobson & Margolin, 1979; Stuart, 1980), assign homework to clients to encourage verbal and nonverbal expressions of positive feelings among family members. For example, a couple might be given the following task:

We have already discussed several ways that you showed your partner you cared in the past (e.g., give flowers or a card, fix dinner, tell partner you love her or him, etc.). Between now and next session I want you to find at least two ways (old or new) to show your partner that you (love, care, appreciate, respect, etc.) her or him.

As in the previous example, the therapist can set up a challenge to "figure out what your partner did" so that each becomes more perceptive about positive interchanges and subsequently discusses these positives in therapy.

Cooperative Climate for Solution Construction

Nowhere in the theory and practice of solution-focused therapy do emotions play a more obvious role than in establishing and maintaining a cooperative therapeutic climate in which the client begins to *expect* change. De Shazer (1985) states:

> . . . influence in the therapeutic context needs to be constructively used to create for the client the expectation of noticeable change—which is what the therapist is paid to do. (pp. 69–70)

The solution-focused therapist deliberately influences clients toward a more positive view of their situation by asking them about exceptions and what is working well for them. The therapist is also free with compliments regarding what the client is doing well and also supports interactions in which the clients are likely to compliment one another. The therapist creates a cooperative climate by avoiding confrontive techniques and maintaining a nonjudgmental, accepting, collaborative position in relationship to clients. This encourages in clients an accepting frame of mind, or as Milton Erickson might say, a "yes set" (de Shazer, 1982; Erickson, Rossi, & Rossi, 1976; Erickson & Rossi, 1979).

Some clients feel threatened by therapy and have a hard time sharing. When therapists respond to clients' hesitancies about discussing certain issues by saying, "You don't have to talk about it right away" or "I am pleased that you are comfortable enough to let me know what you are willing to share and what you are not," they verbalize acceptance, which helps clients feel relaxed and secure enough to work on solving their presenting problems.

Compliments may also be used to support clients' strengths, reduce their anxiety, and help create a cooperative climate. Sometimes, however, clients will present their situation in terms that leave little room for compliments. In those cases where the clients may be expressing strong negative emotions, compliments may still be found. For example:

> You really impressed us with your clear description of how angry, hopeless, and frustrated you feel. Each one of you helped us understand how bad things are, and why and how what you've tried has not helped.
>
> What was really striking was how intensely each one of you felt about all of this, and how you all share the same wish that things be different and that you get along better and be happier together.
>
> It seems to us that if you didn't care so deeply about each other and your family you would not even bother to come and share your hurts with us. The fact that you are so loyal to each other and haven't written each other off seems to indicate that deep down you are hoping that things will get better.

Emotions as Exceptions

Positive emotions can be used as exceptions or to build exceptions. For many clients it is difficult to feel motivated to improve a relationship when their principal emotions are negative. Negative emotions may cloud their perceptions, affect their behaviors, and dampen

their motivation to act differently. Thus, highlighting clients' positive emotions and building upon them can assist them to take positive action and to put their negative emotions in perspective. For example, when a client in a conflictual relationship says that he/she still cares about his/her partner, the therapist could reply, "So there are some good feelings still involved?" The therapist could then ask the client: "Do you think your wife knows you feel like that?" "What are those times like when you are experiencing those feelings?" "What could each of you do to increase the percentage of time you feel those feelings?"

Similarly, after the discussion of an angry interchange between a father and an adolescent, the therapist might say:

> Have you thought of how you could have handled that differently so you didn't feel so angry and your son was a little more cooperative?

In the above example, the therapist might also say:

> Behind your anger, are you also a little disappointed in your son and in your relationship with him? Are you a bit sad for not having the relationship you'd like? You seem to want so badly for things to turn out differently.

Here the therapist raises with the father the possibility of disappointment and sadness behind his anger. This provides a different frame for his emotional state, one that might encourage him to share more directly his vulnerability and caring and motivate him to interact differently with his son (cf. Alexander & Parsons, 1982; Greenberg & Johnson, 1988).

Solution and Problem Patterns

Eliciting exceptions is, as stated earlier, an integral part of solution-focused therapy. Solution-focused therapists can evoke affective, cognitive, and behavioral differences between those times when family members are getting along (i.e., the solution pattern) and times when they are not (i.e., the problem pattern). Such a search for exceptions not only invites solutions, but also encourages clients to stay in a solution-seeking mode. Typically, solution-focused therapists focus more on cognitive and behavioral differences. However, by eliciting and linking emotional, behavioral, and cognitive changes, the therapist can more vividly underline differences between problem and solution-seeking patterns. Possible questions include:

> "When your spouse is (less angry, less depressed, happier), how do you feel differently about yourself?"
>
> "How do you treat her or him differently when you're feeling less (guilty, responsible, burdened, worried)?"
>
> "What do you need to do differently to feel less (guilty, responsible, burdened, worried) regardless of how your partner is acting or feeling?"

It may also be helpful to have clients gain a metaview of both problem and solution patterns of interaction as they relate to certain emotions. Here is an example:

> "What are signs that you are depressed or upset about something? (Answer: "When I get quiet and stay to myself.") "What would happen if you talked to your partner during those times and told her how you felt?"

Setting Goals

The solution-focused therapist typically helps clients define clear, specific goals (de Shazer, 1985; Miller & de Shazer, 1989; O'Hanlon & Weiner-Davis, 1989). Through the process of creating goals, solutions (i.e., desired behaviors) are easily generated. Unlike de Shazer (personal communication, January, 1987), we believe that emotions should be overtly

incorporated into the goal-setting process. For example, "I want to stop yelling at my son" might be followed by, "How will you feel differently when you are not yelling at your son so much? When you feel (calmer, more relaxed, less angry, etc.), how will you respond differently when your son has a bad day?" Thus, the client's emotions are used to elicit behavioral descriptions of their goals. Such responses also have the effect of increasing empathy and interpersonal sensitivity among family members.

Scaling

A frequently used technique in solution-focused practice is to ask clients to quantify their complaint. The purpose of this is (a) to provide information for the therapist and client about the frequency and extent of the problematic behavior in relation to exceptions and (b) to further define therapeutic goals. It is particularly useful when the complaints are vague and imply almost no exceptions. The wording of the scaling questions should conform to the client's way of describing the complaint in order to maintain a cooperative stance. For example, after a client says, "I feel depressed almost all the time," a solution-focused therapist might ask, "On a scale of 1 to 10—with 1 being the most you ever feel depressed and 10 being the least—how depressed are you presently feeling? Is that more or less than during last week ... month? What will you be *doing* differently when you can feel you are 5% less depressed? What will your family be doing differently?"

Similarly, in another example, a solution-focused therapist might ask, "On a 10-point scale how happy are you in your marriage, with 10 being the happiest you ever could be?" and "What is one small thing you and your wife could do this week to get from a 5 to a 6?"

Charts

Graphs and charts can also be used to help clients gain a better understanding of events that might contribute to positive and negative feelings. For example, clients can rate their marital happiness on a 10-point scale each day of the week and observe any fluctuations that might occur (cf. Jacobson, 1987). The therapist can use this information to discuss "exception" behaviors or events associated with high levels of marital happiness.

Another example is illustrated in the case of a 30-year-old divorced male seen for feelings of hopelessness and depression. He had been separated for 2 years, believed he had no control over his depression, and was having a hard time moving on with his life. As a result, the following intervention was given:

> Each night I want you to indicate on a piece of paper whether you will be happy, somewhat happy, somewhat depressed, or depressed the next day. The following evening you are to look back on your day and decide whether your prediction was accurate or not, marking it down, and then rate your degree of happiness or depression for the next day. (Molnar & de Shazer, 1987)

After 2 weeks, the charts indicated, to the client's amazement, that his predictions were almost always correct. He then began to identify (a) specific events that led him to be unhappy (e.g., contact with his ex-wife on weekends), (b) what days he tended to be most depressed (i.e., Mondays and Tuesdays), and (c) what he could do to minimize his depression (e.g., see his ex-wife less, interact with her in a more business-like manner, and achieve most of the daily goals he had set for himself). Eventually, with work, the client became only slightly depressed on Sunday nights and experienced minimal depression the remaining week.

SPECIFIC SOLUTION-FOCUSED QUESTIONS

The question/response process is a primary means of developing a cooperative solution-focused therapist-client relationship. When done well, it connects solution-focused therapists and clients cognitively, behaviorally, and emotionally.

Questions asked during the interview also can be major therapeutic interventions (Tomm, 1987, 1988). What follows is a partial list of solution-focused therapy interview questions that integrate the use of emotions and, we believe, encourage clients toward positive changes.

Individual Questions

"Who do you think will notice first when you begin to feel better?" (Lipchik & de Shazer, 1986).

"Are you more or less depressed now than the last time you saw a therapist?" (Lipchik & de Shazer, 1986).

"What do you suggest you do when you are feeling this way?"

"And when you start acting differently, how do you usually feel?"

"When you are feeling as distraught as this, who is usually most helpful?" (Lipchik & de Shazer, 1986).

Couple Questions

"What can your partner do that will help you be more loving toward her/him?"

"When you are more loving toward your partner, how does he treat you differently?"

"How do you feel differently since you and your partner began to fight less?"

"When you're feeling loved (appreciated, respected, etc.) by your partner, what is s/he doing differently? Are you able to convey to your partner that his/her behavior has the ability to change your feelings? What would need to change for you do that?"

"When you are feeling (empty, scared, pressured, threatened, etc.), what is the best thing for your partner to do? Do you tell him/her to do that?"

"Roughly, what percentage of the time that you are interacting with your partner do you feel he/she is treating you with respect? What exactly is s/he doing at that time?"

Family Questions

"What are you likely to be doing together the next time you all find yourselves laughing?"

"(To child) What do you do to keep from worrying about your father's drinking?"

"Who worries about your daughter the least, you or your partner?"

"When your daughter becomes upset, how does it leave you feeling? How do you cope with this feeling?"

"What will your husband be doing differently to support you so that you are less frustrated with your daughter?"

"When you are feeling guilty about your son, what do you think you are thinking?"

CONCLUSIONS

The purpose of this paper was to examine the role of emotions in solution-focused therapy and to suggest several ways affect could be utilized better within this model. We believe that solution-focused therapists can expand their ability to bring about change by more directly and consciously incorporating emotions into their therapy, especially in cases where emotional themes are predominant (e.g., themes of hurt, abandonment, and issues of trust). Hopefully, our thinking and suggestions for such an integration will prove useful to the practicing clinician.

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Solution Focusing the Next Generation: The SPACE Model in Practice

Introduction

Written and designed by Tara Gretton

The SPACE model is a living metaphor and a practical structure rooted in the solution-focused approach. It integrates what we know from practice, neuroscience, and the lived experiences of young people. At its heart, it's about creating emotional, relational, and physical space-so that young people can be believed, noticed, and supported to uncover what's already working in their lives.

Rather than asking, "What's wrong?" the solution-focused approach invites us to ask, "What's already helping?" or "What might be a little better?" Through gentle, curious, and permission-led conversations, we create the conditions for young people to feel safe enough to reflect and imagine.

S - Safety and Slowness (Pace)

"We're not rushing. This is your space."

We begin by offering safety-not just physical, but emotional and relational safety. A co-regulated space where there's no pressure to speak, no rush to perform. The pace is gentle. It's in this slowing down that reflection, emergence, and trust can grow-hallmarks of a solution-focused stance.

P - Power and Preferred Futures

"If things were a little better, what might be different?"

We shift the balance of power, inviting young people to co-create their own preferred future. This solution-focused principle honours their voice, their timing, and their hopes.

A - Agency and Awareness

"What have you already done that helped, even just a little?"
"Can I share something with you about how the brain works in relation to...?"

Here, we gently amplify what's working and invite insight. Solution-focused questions grow awareness. Psychoeducation is introduced with permission, building understanding.

C - Connection and Compassion

"What's ok to talk about today?"

This is about presence, offering choice, and creating a felt sense of connection. That's when compassion and self-compassion can re-emerge-something that flourishes in a solution-focused, relational space.

E - Exceptions and Evolution

"Has there been a time, even once, when this was a little better?"

We attend to the tiniest signs of difference. These become the starting points for change-core to solution-focused practice.

Stories That Show What's Possible

A 14-year-old girl, adopted at birth, had disengaged from therapy. She focused on hopes: managing school emotions, improving staff relationships. That became her story.

An 11-year-old boy who struggled to speak found meaning through gardening and selected SF questions like "What brings me joy?" His words guided our way forward.

The Golden Thread

Solution-focused work isn't meant to stay in therapy rooms. When rooted in belief and relational care, it weaves through classrooms and homes. That's when we move in rhythm.

The Science: Why It Works

When young people feel safe, seen, and respected, oxytocin is released:

- Reduces cortisol
- Activates social engagement
- Builds trust
- Supports learning and growth

Solution-Focused Assumptions = Inclusion in Action

- People are experts in their own lives
- Change is already happening
- Small steps matter
- Every conversation holds potential

The SPACE model brings these assumptions alive-embodied, inclusive, and dynamic.

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A Brief, Informal History of SFBT as Told by Steve de Shazer and Insoo Kim Berg

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This account of the origins and development of SFBT is not based on a rigorous historical analysis of key events, recovered unpublished documents, or the formal writings of de Shazer, Berg, and their colleagues at the Brief Family Therapy Center (BFTC). Rather, it is taken from the author's records of two experiences he had with de Shazer and Berg: 1) notes from a lecture de Shazer gave about the history of SFBT just one month before his death, and 2) a recorded interview with Berg in 1998 about the origins of BFTC and SF techniques. The article concludes with a few reflections by the author.

In the latter part of the summer of 2005, I (Peter De Jong) came to Milwaukee, Wisconsin from Michigan for a couple of weeks as I had done every summer since 1990. I came mainly to work with Insoo Kim Berg on our joint projects and related writings. I would, however, also sit in on the workshops Insoo and Steve conducted each summer, and stay at their home, so we could discuss the workshop content and the participants' responses to the material. These discussions helped inform Insoo's and my writing about how to make SFBT more accessible to learners. The workshops were always run by Insoo. I would sit next to Steve, both of us drinking coffee, until Insoo asked one of us to do something; such as a demo of a miracle question conversation or address a particular topic. Insoo began that 2005 summer workshop as she always did, asking the participants what they would like to have heard, seen, or done by the end of the workshop. Predictably, among the requests was the wish to hear about how Steve, Insoo, and their colleagues at BFTC developed their innovative SF techniques. So, part way through the workshop Insoo asked Steve to talk about the history of the approach, and I took notes on what he said. The version of BFTC's history contained in this article is reconstructed from those notes. It is supplemented with quoted comments from Insoo taken from a recorded interview I did with her in 1998 about the origins and development of SFBT. I conclude the article with my reflections from Steve's lecture and Insoo's comments.

Steve & Insoo's Telling of the History

The story begins in the 1970's at the Mental Research Institute (MRI) in Palo Alto,

California. There, the likes of Don Jackson, Jay Haley, and John Weakland had been developing a form of brief therapy since the inception of MRI in 1958. Steve and Insoo, both from Milwaukee but unknown to each other at the time, came to Palo Alto wanting to learn more about the ideas and practices of MRI. They learned, among other things, that MRI's practice was, in part, inspired by the work of the psychiatrist Milton Erickson. Some of MRI's therapists including Haley, would visit Erickson in Arizona and talk to him about his cases. Haley, especially, has written about Erickson's work describing many of his cases (Haley, 1986). Erickson's practice with clients was short term, sometimes included hypnosis, and always involved Erickson doing something to bring about change.

Steve became fascinated by Erickson's work. While Erickson did not develop and write about a detailed model of doing therapy, he did describe many cases and what he did with them. For example, there was the case of a twenty-one-year-old woman who came to Erickson saying she was thinking of ending her life. She said she wanted a husband and children but had never had a boyfriend and felt she was too unattractive to attract a man. She said she worked as a secretary at a construction firm and kept to herself. There was a young man at work who she found attractive, who showed up at the drinking fountain when she did, and who seemed interested in her; however, she never spoke to him. She had no friends and believed she was "too inferior to live." She decided to see a psychiatrist before ending her life, telling Erickson she would work with him for three months before carrying out her plan.

Erickson thought the woman was pretty but dressed very unattractively and her hair was stringy and unevenly cut. The woman told him her main physical defect was a gap between her two front teeth which she self-consciously covered with her hand when she talked. Erickson responded to the woman by assigning two main tasks. First, he told her that since she was going downhill anyway, she might as well have one "last fling." She was to go to an assigned store and get help selecting an attractive outfit and then to an assigned beauty shop to have her hair styled. Erickson said she accepted the task because she did not interpret doing the task as improving herself but only having a "last fling." Second, she was to go home and, in her bathroom, practice filling her mouth with water and then squirting the water through the gap in her front teeth. She was to practice until she could squirt the water up to six feet and do so with accuracy. Erickson said she thought this was a silly task, but its silliness apparently prompted her to go home and practice it conscientiously.

When the woman returned and was attractively dressed, her hair newly styled, and skillful at squirting water through the gap in her front teeth, Erickson proposed another task. This time she was to play a practical joke at the office. The next time the young man appeared at the fountain, she was to fill her mouth with water, turn, squirt it at him, run toward him a bit, and then immediately turn away and "run like hell down the corridor." At first, the woman rejected this proposal as ridiculous, but later decided it could be part of having one "last fling." So, the next day she went to the office dressed in her new outfit and looking very attractive. When she approached the water fountain the young man predictably appeared. She filled her mouth with water and squirted it at him. He yelled an expletive at her which made her laugh; she then turned and ran down the hallway. The young man chased her, caught her, and to her astonishment, kissed her. The next day, the young woman nervously approached the water fountain. The young man was hiding nearby and jumped out squirting her with a water pistol.

Steve studied scores upon scores of Erickson's cases trying to figure out his way of working with clients. Insoo had this to say about Steve's study of Erickson's work:

> He (Steve) is the type that when he's interested in something he just reads and reads and reads …. That's what he did with Erickson's work; he just immersed himself. And he's always looking for patterns that connect. So, he looked a lot really into Ericksonian patterns – what is it about his way, how can he describe the patterns – that seem so out of nowhere.

Steve came to see at least two patterns that connected in Erickson's way of treating cases. First, Erickson heard and tied his tasks and proposals for the client to the client's goal. In the case of the young woman, he heard that she wanted a husband, a family, and friendships. Second, he creatively drew on qualities and skills that the client possessed and could be put to use in reaching the client's goal(s) (the principle of utilization). In the case of the young woman, she had a space between her two front teeth and she mastered squirting water through that space.

Steve also noticed that Erickson's brief way of doing therapy -- often in just a few sessions -- was radical because it came at a time when therapy was indefinite. Many therapists believed clients regularly needed one-hundred or more sessions. When research studies at the time showed the average number of sessions for clients was about four sessions, therapists would bemoan this and say things like: "the client's progress is only a temporary flight into health," or "the client's quick progress did not address the real or underlying problems," or "leaving therapy so soon is a defense mechanism; it is a sign of client resistance to getting better."

In thinking about these common therapist explanations in the 1970's for the average few number of sessions, Steve and his colleagues saw a "big disconnect" between these explanations and what their clients were telling them. As Insoo described it:

> In that time (early to mid-1970's), families kept dropping out and dropping out of treatment. Families don't tend to stay in treatment very long. Couples don't tend to stay in treatment very long. And I didn't know that at the time. So, I kept getting this uncomfortable feeling that this isn't right, this isn't right. The clinical phenomenon and what the theory says didn't go together. So, I was in search for something – there must be an answer for this …. And I think that another thing that was interesting was that these 'failure cases' because by their (most therapists') criteria – anything less than people who stay in treatment for less than a year – was a failure case -- because they are dropouts. Yeah, (but) dropout cases were sending their best friends, their family members … I only saw them three times and they must have thought that I helped ... because they are

> sending their sister, their mother – so I thought something isn't right, something isn't right, but I didn't know what.

As a consequence of this "disconnect," Steve and Insoo began looking more carefully at the existing data about number of sessions. They saw that mental health facilities at the time were taking as many as six sessions to do extensive assessments before they began treating the assessed problems. Clients often "dropped out" before the assessments were completed. Nevertheless, clients said coming to the sessions had been helpful. Other data indicated 80 to 90 percent of therapy was less than 20 sessions; yet, most clients said therapy was useful. Steve then realized that clients were using therapy differently than most therapists thought they should. With Erickson's work and the data about client number of sessions as background, Steve thought: Let's build a brief therapy around the client goals; they obviously are using therapy that way anyway. So, he decided to listen more intentionally to and believe what clients say they want and say is useful for them. Meanwhile, by this time which was in the later 1970's, Steve had returned to Milwaukee and joined the large family service agency where Insoo worked. Insoo had put a one-way mirror into her large office so she and colleagues could observe practitioners working with clients. They and their colleagues soon discovered that they could not simply ask the client: "What is your goal?" When they did that, the client would respond "to stop drinking," or "to stop fighting with my teenage son," or "to be less depressed." These client responses were more like problem statements rather than goals. Accepting these responses as goal statements was not useful because practitioners know the hardest way to change is to try to stop something. Soon, Steve and Insoo observed and recognized that the clients who were making progress had discovered something else to do instead of the problem behaviors. So they began experimenting with questions like: "What are you going to do instead of the drinking?" "When you are not drinking, what will be there instead?" "What will be happening when you are not drinking anymore?" "What will others notice you doing when you are not drinking anymore?"

These questions, too, were difficult for clients to answer. Clients would often first respond, "I don't know." So, Steve, Insoo, and their colleagues (who by now had formed BFTC in 1978) kept working at ways to ask questions about client goals in order to give clients maximum opportunity to construct useful goals for themselves. And then, in the early 1980's, Insoo had the case of a woman who came to her saying she was depressed and was contemplating killing herself. She had several children with many problems themselves and a husband who drank too much alcohol and was out of work. Insoo began goal work with the woman asking questions like: "so what needs to happen here for you to say our meeting was useful?" And, "what do you want different by the end of our work together?" To these and several similar questions, the client responded "I don't know" and she continued to give more details about the problems of her family and herself. Then, at one point the woman added the words "unless a miracle happens" to her "I don't know's." Insoo, by this time intentionally attendant to client words, picked up the phrase and asked: "Okay, so suppose a miracle happens and all these problems are over, what would be happening instead?" The woman then began to answer, "my husband would stop drinking and have a job," and "I would have more energy." Insoo continued with "what else would be different?" The woman responded with "my kids would be doing better in school." As Insoo continued following up on each client answer and getting more details, she and the team noticed the woman became more animated and seemed less depressed and more hopeful. The differences in the woman from the beginning of the session to the end impressed the observing team so much that they decided, as they had been doing with each promising new technique, to ask the "miracle question" of all clients for the next several months and see what difference that made in the rates of client progress. The "miracle question" turned out to be so useful that BFTC made asking it a standard practice of their developing new form of brief therapy. Insoo has commented that the observing team at BFTC did not invent the miracle question; instead, it came from listening carefully to what clients say and then using that:

> You know, I think clients say that stuff all the time: "do you have a magic pill?" Or, "do you have an answer to this?" "I need an answer from you." "I need a miracle from you." "Or a magic wand from you." I think clients say that all the time… But sometimes when the event, the case, and the circumstances come together, *you hear them*! (italics added) And I think that out of desperation (laughing), when the case seems so hopeless; out of desperation you hear them. That's what happens a lot; and you get new ideas. It comes from that, not that we are so brilliant or so smart. But I think that, "oh my gosh, what do we do now?" creates that kind of crossroad, and then something opens up I think.

Steve says the same sort of careful listening to the client and then building on what he heard led to the use of scaling questions in SFBT. Steve had a case shortly after the release of the American film "10" starring Bo Derek as a beautiful young woman and Dudley Moore as a middle-aged composer. Moore's character, experiencing a mid-life crisis, becomes infatuated with the young woman whom he rates as "11" on a scale that only goes up to 10. The film was very popular and the practice of rating things on a 10 point scale was finding its way into popular culture. Steve's case was a man who was returning for a later session and Steve asked him how he was doing. The man said: "I'm doing better." Steve asked: "How much better?" The man replied, "Well, I'm not a perfect 10; but I'm about an 8.5." Then Steve asked: "So what tells you it's 'about an 8.5'?" The client went on to describe the progress he had been making. After that case, and through discussion and reflection with Insoo and his colleagues, Steve came to realize scaling was so useful because the client had to be scaling himself relative to his own goal(s), not some professional, supposedly objective, criterion of success. And, in asking the client to provide the details for the number he gave, the client and Steve became clearer about what it is the client wanted different in his life which, in turn, made deciding what to do next easier.

Once it dawned on Steve that the client's goal was implicit in the scaling numbers for

progress, he also began to notice that many clients who were making progress came into later sessions already describing what was better. Implicit in these descriptions was what clients wanted different in their lives, i.e. their developing goals. So, Steve and his colleagues began asking "what's better?" at the beginning of follow-up sessions and then lots of follow-up questions to get the details of what was better. This began in the early 1980's and was a new direction because in the late 1970's and into the early 1980's, BFTC practitioners were still influenced by practice at MRI and would give clients tasks intended to bring change. As the tasks were intended to change clients and/or their situations, it was natural to begin later sessions by asking clients whether they had done the tasks and what the results were. In shifting toward conversations about what was better and away from asking whether clients completed their tasks, Steve and his colleagues discovered most clients, if asked, could identify something better. As BFTC practitioners pursued this new line of questioning, figuring out more and more ways to keep the conversation about what was better going, even when some clients would start out by saying "nothing," they found over 90 percent could identify something better. The more they stayed with the "what's better" opening in their follow-up sessions, the less they focused on asking about tasks and designing intricate tasks based on family systems thinking as they had been doing earlier. Steve says a bonus to shifting toward asking "what's better" was the discovery that what clients described as "better" often had nothing to do with the original problem(s) that brought them to therapy. The bottom line here, Steve says, is that clients define success differently than most practitioners who try to help clients by assessing and solving their problems. He came to realize that in listening ever more intentionally to what clients want and inventing with them more and more ways to invite them to describe in detail what they want and the progress they are making, clients were teaching the practitioners at BFTC to move away from problem solving in favor of building solutions in partnership with them.

Reflections

I (the author) am struck by three things in Steve's brief telling of the history of BFTC and SFBT. The first is his focus on just a few years of that history; namely, from the mid-1970s to the mid-1980s. I wonder if this was the period, in his mind, when the key discoveries were made at BFTC. It was the period when BFTC began abandoning the theories and practices of the field of psychotherapy in general and differentiated itself in practice and thinking from MRI. It is also the brief period during which the unique solution-focused questions and practices were invented at BFTC that have endured to the present as heart of SFBT.

Second, I am struck by Steve's emphasis throughout that the team at BFTC learned to listen to clients in a different way. While the rest of the field was using professionally constructed categories to assess client problems and then move to helping clients with related interventions, BFTC practitioners were learning to listen to clients on their terms versus the lens of the field. Steve and Insoo first noticed the "big disconnect" between the field's view about how much therapy clients needed and how clients were using just a few therapy sessions and finding that useful. BFTC believed the clients about the usefulness of just a few sessions and began listening more intentionally to what clients said they wanted and what progress they were making. In a sense, BFTC closed the textbooks about how to do therapy in favor of listening to their clients. And, as Insoo said, "…sometimes when the event, the case, and the circumstances come together, *you hear them* (the clients)!" The increasing BFTC capacity to hear clients on their terms rather than through professional categories, led to the signature SF questions and practices.

Third, I am impressed by the approach to investigation and knowing that BFTC adopted. While early on Steve and Insoo experimented with practices drawn from family systems theory, they soon set that approach aside in favor of direct observation of therapy sessions. Insoo put a one-way mirror in her office at the family service agency in the 1970's. One-way mirrors and direct observation and review of recorded sessions remained a central feature of practice, research, and learning at BFTC until Steve and Insoo's passing. The colleagues at BFTC consistently observed for which clients were making progress and what those clients and their practitioners were doing together that might be contributing to that progress. When they noticed a client and practitioner collaborating in a new and potentially useful way (such as Insoo picking up on her client saying "unless a miracle happens"), they incorporated the innovation into their practice and formed a research study to measure its usefulness. Employing rigorous observation of real time and recorded sessions is what contributed most to listening to clients in a new way and the invention of SF techniques. Steve, in a book published in the 1990's reaffirms the importance of such observation:

> Therapists are interested in the doing of therapy and, at least in a certain sense, only the observation of sessions or watching videotapes of therapy sessions can give them the 'data' they need [to learn SF and improve their practice skills] (de Shazer, 1994, p. 65).

Reviewing these notes from Steve's 2005 lecture and the 1998 interview with Insoo has gotten me thinking that we may have more to learn from this version of the history of SFBT than I first realized. Many of us who teach workshops and write about SF practices, tell our learners that SF is "simple but not easy." That is to say, it is simpler to describe, understand, and teach the SF approach in concept than it is to actually conduct a SF conversation. On reflecting once again on Steve and Insoo's history described in this article I wonder if we have ignored some of their genius in our teaching. I know that for the nearly thirty years that I have been teaching and practicing the SF approach, I have focused mainly on teaching the SF questions invented at BFTC together with the outlook about clients and practice embedded in those questions. This question-based approach largely ignores how SF questions were invented. In contrast, Steve, Insoo, and their colleagues themselves first "learned" the SF approach through direct observation of therapy sessions and listening to and learning to hear clients on their own terms. Having recorded sessions allowed them to revisit the words of what clients said and stay close to those words so as to reduce the natural tendency (often

unintentional and below the level of awareness) to transform what clients say into the practitioner's preferred or professional categories. Perhaps, I am thinking more and more, SF learning would be enhanced by consistently having our learners record their SF interactions from the outset of their learning. That is easier than ever to do with smart phones, laptop computers, and role playing. The teaching can then be organized around inviting learners to observe for what their "clients" are saying and what they and their clients are doing together that contributes to clients constructing detailed visions of what they want and measuring progress toward these goals as the clients define progress. In organizing SF learning around learners becoming keen observers of their own SF conversations, they will be reinventing the SF model for themselves. Doing it this way originally worked well for the BFTC team; perhaps shifting our teaching in that direction will produce similar results for today's SF learners.

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