

Dr. John Murphy has done a splendid job of capturing the concepts and techniques of solution-focused therapy that clinicians can integrate into their therapeutic practice, regardless of their theoretical orientation. Highlighted are the collaborative relational stance, the unique strengths of this approach, and the centrality of encouraging client feedback, which is used to enhance the therapeutic process. The book is a scholarly treatise, yet the author presents the spirit of this approach in a conversational, personal, engaging, and practical way.

—**Gerald Corey, EdD, ABPP**, Distinguished Visiting Professor of Counseling, University of Holy Cross, New Orleans, LA, United States; author, *Theory and Practice of Counseling and Psychotherapy* (11th ed.)

Solution-Focused Therapy is highly informative and well written, practical and engaging, with numerous illustrative transcripts and lots of useful supporting worksheets and guidelines. I knew Steve de Shazer and Insoo Kim Berg, the originators of SFT, and I believe that they would be very pleased with Dr. Murphy's fine contribution. Highly recommended!

—**Michael F. Hoyt, PhD**, author, *Brief Therapy and Beyond: Stories, Language, Love, Hope, and Time*; coauthor, *Brief Therapy Conversations: Exploring Efficient Intervention in Psychotherapy* (with F. Cannistrà)

John J. Murphy has always been my favorite solution-focused therapist and writer. Alongside his laser focus on client strengths, resources, and potential, he is relationally oriented. His kindness and empathy shine through in everything he writes.

—**John Sommers-Flanagan, PhD**, Professor, University of Montana, Missoula, MT, United States; coauthor, *Clinical Interviewing* (7th ed.), *Counseling and Psychotherapy Theories in Context and Practice* (3rd ed.), and several other books

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Introduction

Trey entered the office cautiously and took a seat across the table from me.¹ He glanced around the room at the bookshelves, wall hangings, and a few other items—anything but me. Trey, a 9-year-old African American student in an inner-city elementary school, was referred by his teachers for a psychoeducational evaluation due to academic problems. As the school psychologist, I was required to complete a social history interview and form at the start of every evaluation, which typically took about 5 minutes. As it turns out, my conversation with Trey that day was anything but typical.

After a few introductory comments, I asked who he lived with at home. “My aunt and five cousins,” Trey replied. His school file stated that he had been removed from his mother’s custody the previous year due to child abuse and that his father died when Trey was 6. When I told him I was sorry about his father’s passing, he quietly told me his father

¹In all clinical case material in this book identities have been disguised and other steps have been taken to protect client confidentiality.

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was murdered by “a guy named George” in the kitchen of their apartment. “They were yelling, and George shot him. The police came and took George away, and they took me to my aunt’s house.” The social history interview had taken an unexpected turn.

“I bet it’s hard not seeing your dad,” I said. Trey nodded and described other struggles involving various family members. He had two older brothers named James and Robert. James was in prison and Robert was on probation. Trey had been in three different schools during the past 3 years. After telling me his aunt might move again, he put his face in his hands and sobbed.

We sat in silence for a minute or so before I noticed a few tears collecting on the table under Trey’s face. I was at a loss for words. We sat for another minute, Trey with his face in his hands and me staring a hole in the table. I couldn’t shake the idea that Trey had suffered more in 9 years than some people do in a lifetime.

I finally broke the silence. “With everything you’ve been through, how do you keep hanging in there and coming to school?”

Trey looked at me for the first time and said, “My aunt always tells me to never give up because quitters don’t make it.”

I followed his lead by asking, “What else does she say or do that helps you?”

Trey replied, “She’s always saying, ‘try hard,’ ‘do your best,’ and stuff like that. And that I’d be the first one in the family to graduate from high school.”

When asked what else kept him going, Trey described several coping skills and other resources. I felt myself becoming more hopeful, and Trey seemed more energized as the conversation shifted from what was wrong or lacking in his life to what was right and working. He spoke faster and with more expression. He leaned forward, held his head higher, and made more eye contact. Among other things, I learned that his brother Robert occasionally helped him with homework and that he did better in math when teachers gave him more time to complete class work. I thanked him for talking with me and walked him back to class.

Trey and I completed the evaluation a few weeks later, and my report included the following recommendations taken directly from our previous

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conversation: additional homework help from Robert, extra time for math work in class, tutoring from older students at school, and continued encouragement from his aunt. Although I did not think of it in these terms at the time, every suggestion was built on what was already available and working in Trey's life—his ideas, social supports, and other indigenous strengths and resources in his life.

I began to search for a more systematic way to initiate collaborative, client-directed, strengths-based conversations like the first one with Trey. The search led to a small group of clinicians in Milwaukee, led by Steve de Shazer and Insoo Kim Berg, who were experimenting with an innovative brief therapy approach. They called it “solution-focused” brief therapy to highlight the emphasis on what clients wanted from therapy and what they were already doing or already had in their lives that would help toward achieving it. This book uses the shorter term *solution-focused therapy* (SFT) to capture the approach's essence and distinguish it from problem-focused approaches that have dominated the psychotherapy profession for over a century.

WHAT IS SOLUTION-FOCUSED THERAPY?

SFT is a collaborative approach that invites clients² to describe what they want from therapy and apply what they already have in place toward achieving it in the shortest time possible. Therapists are guided by three self-talk questions:

- What does the client want from therapy?
- What does the client already have toward achieving it?
- What progress has the client already made and what are some possible next signs or next steps toward further progress?

²In this book, the term *clients* refers to individuals, couples, families, or other therapy participants. *Therapists* and *practitioners* include psychotherapists, psychiatrists, counselors, social workers, and other service providers. *Therapist* is used in client illustrations and dialogues for the sake of consistency. *Solutions* refers to positive steps toward desired outcomes rather than ideal outcomes or absence of problems.

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These questions translate into the following three main tasks of SFT:

1. *Setting a direction* on the basis of what the client wants from therapy: What are your best hopes from talking with me? How would your life be different if you achieved those hopes?
2. *Building on exceptions and other resources* that are already happening and available in the client's life: When is/was the problem less noticeable? Tell me about a time your best hopes have happened. How did you make that happen? What/who else might help you move closer to your best hopes?
3. *Exploring progress* toward desired outcomes: What's better since we last met? How did you move up on the 0–10 scale? What might be the next small sign/step toward further progress?

These tasks represent the entirety of SFT and occur in varying degrees and sequences during most sessions.

Th *three main techniques* of SFT are *asking*, *listening*, and *amplifying*. Therapists ask useful questions, listen closely to clients' responses, and amplify aspects of their responses and lives that support desired outcomes. When being purely solution-focused, there is rarely anything else the therapist does outside of these activities. The defin tion of SFT highlights several key features. SFT is:

Collaborative

SFT is a collaborative, client-directed approach that invites clients to participate in every aspect of therapy to the extent they are willing and able to do so. In contrast to approaches in which therapists prescribe interventions based on their expertise and theoretical perspective, solution-focused therapists elicit solutions from clients by approaching them from a position of humility and “not knowing” (H. Anderson, 2007).

Assuming a stance of not knowing does not mean relinquishing one's expertise or influence. As Weakland (1993) noted, “Influence is inherent in all human interaction. . . . The only choice is between doing so without refl ction, or even with attempted denial, and doing so deliberately and responsibly” (p. 143). Microanalysis research indicates that therapists of

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all orientations influence the content of conversation by deciding what to ask and not ask, what to follow up on and let go, and so forth (Bavelas et al., 2014). In SFT, these decisions are guided by the client's goals and responses rather than the therapist's preferences. As Iveson et al. (2012) said, the therapist "would rather be invisible than significant; someone who generates and manages a conversation in which the client hears his or her own words either for the first time or with fresh ears" (p. 127).

Invitational

When SFT practitioners ask questions or offer suggestions, they are presented as *invitations* rather than directives. For a client who reported recent improvements, the therapist might offer the following suggestion: "It may be helpful to watch for small signs of progress. How does that sound to you?" The invitational tone is conveyed by the phrase, "It *may* be helpful" and the question, "How does that sound *to you*?" Presenting questions and suggestions in this manner encourages clients to freely accept, reject, or modify them as needed with no pressure or pushback from the therapist.

Descriptive

Solution-focused therapists elicit descriptions of client hopes, resources, and progress rather than interpreting client actions, motives, and feelings. Consider the following detail-gathering sequence of questions: "What will you notice first when things get a little better? Then what? Who else will notice? How might they respond? What will that be like for you?" Although this sequence of questions lacks the most important element of the conversation—the client's response—it briefly illustrates SFT's emphasis on description.

Focused on What Clients Want

Focusing on what clients want *more* of (vs. less of) is why SFT is considered an *addition* (vs. subtraction) approach. The entire SFT process

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revolves around what the client wants from therapy, which is addressed at the very outset of services (“What are your best hopes from this? What will be different to tell you it was useful?”). Asking what clients want from therapy neither denies the problem nor prohibits clients from discussing problems—it simply invites them to focus on what they want *instead*. This phase of SFT is referred to as *formulating goals* or *setting a direction*.³ Regardless of one’s terminology, the first and most important task of SFT is to determine what the client wants from it.

Focused on What Clients Have

Instead of assuming that client problems indicate personal deficiencies, solution-focused therapists assume clients possess the resources needed to improve their lives. This does not imply that clients would not benefit from additional knowledge and skills. It just means that SFT focuses on helping them build solutions from what is already available and working in their lives—strengths, attributes, successes, social supports, and other resources that can help them achieve hoped-for outcomes.

Brief (Shortest Time Possible)

SFT is brief by design versus default, and every session is approached as if it were the last. This practical mindset expedites change by keeping therapists and clients on track. It also explains why SFT techniques are commonly used in single-session therapy (Hoyt et al., 2018). The “brief” component of SFT does not mean clients are rushed into action or therapists are insensitive to their struggles. Brevity is more of a by-product than a goal of SFT. Therapists rarely set a preestablished limit on the length of therapy

³I prefer the terms *desired* (or *hoped-for*) *outcome*, *preferred future*, and *setting a direction* to the more conventional language of “goals and goal setting” because they effectively portray the SFT process of helping clients describe what they want from therapy and scale their movement and progress toward achieving it. If you prefer goal-based language or are required to use it for documentation purposes, then you can view the client’s desired outcome as a general goal, the preferred future as a detailed goal, and setting a direction as goal setting.

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because that decision, like others, is made in close collaboration with clients. Agencies and therapists that have used SFT for many years have estimated the average length of therapy to be 3 to 6.5 sessions (Macdonald, 2017). Perhaps the most practical guideline for determining the length of therapy was offered by de Shazer, who said “as long as it takes and not one session more” (quoted by Ratner et al., 2012).

Although most therapists do not think of themselves as brief therapists, research suggests they are doing “unplanned brief therapy” (10 sessions or fewer) regardless of their preferences, theoretical orientation, or training (Levenson, 2017). It appears that clients will either achieve their therapeutic goals during that time or drop out if they don’t (Muran et al., 2009; Wierzbicki & Pekarik, 1993). These findings suggest that therapists do not have much of a choice as to whether or not to do brief therapy. The choice is whether to do so by design or default. The fact that SFT has always been brief by design—in combination with its evidence base and multicultural orientation—helps to explain its increased popularity among therapists and clients throughout the world (Neipp & Beyebach, 2022). Since most clients prefer as few sessions as possible, it seems respectful to honor that preference regardless of one’s therapy approach.

SFT AND EVIDENCE-BASED PRACTICE

In 2005, the American Psychological Association (APA) established the Task Force on Evidence-Based Practice to define evidence-based practice in psychotherapy and other psychological services. The task force was made up of scientists and practitioners from diverse theoretical perspectives. Their work resulted in a tripartite definition of evidence-based practice as “the integration of the best available research with clinical expertise in the context of patient characteristics, culture, and preferences” (APA Task Force on Evidence-Based Practice, 2006, p. 273). Since this is part of an APA book series, it seems fitting to address the compatibility between SFT and the three main features of evidence-based practice—research-informed practice, clinical expertise, and client characteristics, culture, and preferences.

Research-Informed Practice

Research and evidence-based practice have played a key role in SFT throughout its history. From the late 1970s to the present, the approach has been examined in descriptive studies, randomized controlled trials, microanalyses, and meta-analytic reviews of outcome studies. These investigations provide extensive evidence of SFT's widespread effectiveness across a variety of clients, countries, and problems (Neipp & Beyebach, 2022).

SFT is also responsive to the well-researched “common factors” of effective psychotherapy. Decades of research have confirmed that the success of any therapy approach depends largely on the extent to which it activates common factors such as client involvement, resources, hope, and feedback—all of which are central in solution-focused practice (Kort et al., 2021).

SFT has also been listed on several federal and state registries of evidence-based practice in the United States. For example, it has been recognized as a promising approach by the Substance Abuse and Mental Health Services Administration's National Registry of Evidence-Based Programs and Practices and the Office of Juvenile Justice and Delinquency Prevention (Kim et al., 2019). Unfortunately, these federal registries were closed due to lack of funding before they could review more compelling evidence of SFT's effectiveness from the past decade. The approach has also been listed as an evidence-based practice by the Oregon Health Authority Addiction and Mental Health Services department (2017). Solution-based casework, which includes many features of SFT, was designated a “promising intervention” by the California Evidence-Based Clearinghouse for Child Welfare (2022). Beyond these formal recognitions, SFT has been widely taught and formally recognized as an effective approach by accreditation programs, universities, and training institutes in many countries throughout the world.

As with any therapy approach, there is a continued need for well-designed studies of SFT with a diverse range of cultures, concerns, and clients, including clients of underrepresented racial/ethnic backgrounds and intersectional identities. Cross-cultural research reviews and

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meta-analyses have verified SFT's credibility as a transcultural, evidence-based psychotherapy that works as well as other approaches in fewer sessions (Beyebach et al., 2021; Neipp & Beyebach, 2022). The efficiency and transcultural evidence base of SFT have increased its usefulness and appeal in community mental health centers, hospitals, outpatient clinics, schools, and private practice settings throughout the world. Chapter 5 examines the empirical evaluation of SFT in more detail.

Clinical Expertise

Clinical expertise in SFT requires the therapist to *ask* useful questions, *listen* to the answers, and construct follow-up questions that invite clients to *amplify* their responses by providing more details. There is rarely anything a solution-focused therapist does outside of these activities.

Although questions are a part of every therapy approach, they are particularly important in SFT. Rather than telling clients what to do, therapists ask questions that encourage clients to tell themselves. The main purpose of questions in most therapeutic approaches is to provide the clinician with information needed to devise diagnoses, interpretations, and interventions. In contrast, solution-focused questions invite clients to describe their “preferred futures” (Ratner et al., 2012) in *their* own words and *their* own way.

The approach's client-directed nature is exemplified by the fact that most of the questions therapists ask are constructed from the client's previous answers and often incorporate the client's exact words. As important as questions are in SFT, their usefulness depends entirely on the client's response. Solution-focused therapists listen with a constructive ear (Lipchik, 2002) tuned to hints of hope, strength, success, and other aspects of clients and their lives that support desired outcomes.

Client Characteristics, Culture, and Preferences

The third component of evidence-based practice emphasizes the importance of tailoring therapy to the unique characteristics, culture, and preferences

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of each client. Solution-focused therapists address this by customizing services to the client rather than requiring them to buy into the therapist's preferred interventions and interpretations. This involves adopting a position of cultural humility; requesting and accommodating client perceptions, preferences, and feedback; and building practical solutions from clients' indigenous strengths and resources. These features of SFT enhance the therapist's ability to provide socially just, culturally responsive services to all clients, including underrepresented persons of various racial/ethnic backgrounds and intersectional identities.

The main tasks and techniques of SFT reflect core recommendations and best practices in multiculturalism and diversity-competent practice (De Jong & Berg, 2013). Starting therapy by asking clients what they want from it—instead of diagnosing them and telling them what they need—sets a collaborative tone for everything that follows. Continuing to anchor questions and conversations to client hopes, resources, and progress further guards against cultural imperialism and other disrespectful practices. The cultural responsiveness of SFT is also reflected by the fact that it continues to grow and flourish in an increasingly wide range of cultures, countries, and client populations around the world (Beyebach et al., 2021; Kim et al., 2019; Neipp & Beyebach, 2022).

THE REST OF THE STORY

Although Trey did not qualify for special education services, he needed additional assistance at school. Building on the exceptions and other resources from our first meeting, I worked with Trey, his teachers, and his aunt to amplify what was already helping him to persevere in school and elsewhere. His math teacher agreed to provide extra time for him to complete class work when possible. Robert stepped up his efforts to help Trey with homework. His aunt was pleasantly surprised to hear about the impact of her homespun sayings and agreed to continue offering words of encouragement. Trey and I also cobbled a few of his aunt's sayings into self-talk strategies he could use as needed.

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Trey continued to struggle academically, though not as much as he had before. At the end of the school year, he proudly informed me that he was promoted to the fourth grade. I congratulated him on his hard work and success. Trey taught me a valuable lesson that continues to inform and inspire my work as a solution-focused therapist: *Every client offers a one-of-a-kind set of life experiences and resources that can be applied toward therapeutic solutions.*