ePSYCHOLOGIE
elektronický časopis ČMPS

2023, Vol. 17, No. 2
Practice reflection

SOLUTION-FOCUSED THERAPEUTIC METHODS

Tomáš Matjaž Zídek

Abstract

Solution-focused Brief Therapy (SFBT) is a particular therapeutic approach that has gained international recognition. It has a strong focus on descriptions of the future, identifying observable signs of progress, and useful behavioral patterns in the client's life. This article describes standard solution-focused interventions that can be observed during Solution-focused Brief Therapy session. These interventions are universal tools that have been used in different fields: organization development, education, coaching, supervision, and more. By reading this article readers will gain an understanding of these basic methods, and how they can be applied. The article is not a supplement for professional education but provides insight into what these interventions can achieve. The reader is encouraged to conceive possible applications of these solution-focused interventions—the purpose of reading this article is to gain a basic understanding of these methods. All of the interventions can be applied inside or outside of the therapeutic context.

Keywords: solution-focused brief therapy; miracle question; scaling question; exception question

Received: 29. 11. 2022
Approved: 11. 5. 2023
Published online: 30. 6. 2023

Introduction

This article briefly introduces the reader to Solution-focused Brief Therapy (SFBT) methods. The article's primary goal is to describe specific techniques participants can observe in an SFBT therapeutic session. This exposition aims to *show* something philosophically relevant about the essence of language—in a therapeutic setting.

SFBT is an internationally recognised approach to psychotherapy; it was developed by Steve de Shazer and Insoo Kim Berg in the 1980s (de Shazer et al., 2007, para. 9.6). SFBT is a particular approach to psychotherapy that possesses several distinct features: the most apparent one is its focus on building solutions rather than eradicating problems—clients are not encouraged to analyse the hypothetical causes of their problems. Instead, therapists prompt clients to explore solutions. These solutions manifest in vivid descriptions of future states where the problem is nonexistent. To enable such conversation, the therapist must deploy *constructive* listening (Iveson, Ratner, et al., 2012). Constructive listening consists in listening for subtle clues provided by the client that can serve as building blocks of potential progress—it is conceptually distinguished from active listening. The difference between the two is significant: constructive listening is selective, as it filters particular parts of the client's expressions. The therapist must listen attentively and carefully select what she reacts to—this distinguishes constructive listening from mere active listening, during which the therapist merely reflects on anything the client has shared.

The philosophy of SFBT is counterintuitive—clients eliminate their problems not by analysing them but by understanding what already works in their life and how they would notice if progress has started to manifest. When clients focus on what works in their life, they identify valuable patterns of behaviour to improve their current state. By focusing on observable signs that can serve as criteria for further progress, they attain a detailed view of the desired outcome of the therapeutic session.

Both of these elements are mandatory conditions of an effective therapeutic process. However, not all therapeutic approaches insist on identifying helpful behaviours and signs of progress as SFBT does. The disadvantage of ignoring these two aspects is subtle: clients who analyse their problems do not achieve more than a theoretical understanding of a past situation that is impossible to alter. When desired therapy outcomes are unknown, both parties cannot be sure they aim in the right direction.

SFBT emphasises the *usefulness* of the therapeutic conversation. This emphasis is manifested through direct inquiries: clients are asked what would be a valuable result of the therapeutic session (de Shazer et al., 2007). In a certain sense, SFBT is the art of having a *useful* conversation—not more, not less. SFBT's aim is not to penetrate the hidden depths of the client to discover eternal truths about human psychology. It sets a seemingly modest goal: generate a helpful conversation. However, this is not an indicator of modesty but of pragmatism.

SFBT emphasises the practical consequences of concepts—including therapy. The stress of utility in SFBT is an expression of a commitment: the validity of therapeutic methods is proven merely by the *outcomes* it produces for clients. Such a statement sounds trivial—therapy must have benefits—an obligation that presumably every therapeutic school accepts. While this is correct, it is this atheoretical aspect that distinguishes SFBT. Therapists assume very little about the clients' nature—they bring no

model clients must embrace to progress. Therapists approach the therapeutic process experimentally: let us attempt this and examine what will happen. Therapists come to every client as an unknown territory—they start from the beginning to *learn* what could mainly work for the client. Therapists do not expect clients to adopt a theoretical model; clients serve as the model themselves. Therapists study the clients. These methods signify that knowledge is not a static reflection of reality—that can serve as a foundation for further deductions. Knowledge is a dynamic infinite social activity that must be continuously validated—not according to its correspondence with extralinguistic entities but to its *utility*.

SFBT inherited this atheoretical epistemological attitude from Wittgenstein, who suggested that philosophers best examine meaning in the context from which it emerges. The context is subject to constant change. Hence, *knowing* a sentence's meaning is temporary and open to prospective disputes.

The role of the therapist alters from a leader whose responsibility is to design interventions for the client to a partner who remains curious to learn more about the client—particularly about what the client is already doing and how she would notice that she has resolved the problem.

The SFBT is a language game consisting of explicit and implicit norms. These norms entail assumptions about the therapeutic process, the role of the participants, and more. Adopting these norms is what establishes the SFBT. It is possible to apply specific methods in isolation. However, such an application does not constitute SFBT.

SFBT's essence does not lie in its popularised methods—a method itself does not make a session solution-focused—but in following complex *norms* throughout the therapeutic relationship.

From these norms, we can derive the central tenets of SFBT:

- Build solutions rather than solve problems;
- The focus must be on the desired future rather than on past problems or current conflicts;
- Clients should increase the frequency of current beneficial behaviours;
- No problem happens all the time—identify exceptions when the problem is not occurring or is happening at a lesser intensity;
- Therapists help clients co-construct alternatives to their behaviours;
- Therapists assume that solutions already exist in the client's repertoire;
- Small changes lead to more significant changes;
- The conversational skills needed for SFBT are different from those needed to diagnose problems.

(Trepper et al., 2014, p. 2)

Solution-focused methods

Solution-focused methods are specific ways to engage the client in a conversation of change—a discussion about prospective options. These conversations focus on exploring opportunities for progress, not analysing presumably static pictures of past events. SFBT sessions direct the client towards building solutions rather than analysing the problem. Collaboratively, the client with the therapist co-construct the desirable future that does not contain the problematic situation (Lee, 2013, p. 5). This co-construction is linguistic—the therapist and the client create a new concept *using* language. The meaning of this concept—the client's preferred future—can hardly be derived from its *representation*. A hypothetical future state of affairs is not a state of affairs in its genuine sense. Under the representational account of meaning, propositions derive meaning from what they *represent* (Biro & Kotatko, 2013; Russell, 2010; Whitehead et al., 1997). But in such a case, what the sentences have to represent has not yet manifested—the object of representation does not exist during the utterance. Therefore, the propositions could not have *meaning* until the future arises. The situation would have paradoxical consequences: all propositions would be meaningless during the discussion about the future. But this is not the case—a debate about a future state is intelligible.

Hence, the concept of a preferred future does not derive its meaning from its representation but from its use—it has meaning because there is a normative *use* of this concept. Regardless of the content of the preferred future, to use the concept is to *do* something afterwards. The role of the concept is to suggest some actions—ideally, some that are *useful* to achieve certain benefits. Concepts are not necessary conditions for activities—we act ordinarily without preconceived notions of what we should do. Nevertheless, for therapeutic clients, this ordinary mode yields undesired results. Their actions—spawned from mere spontaneity or unreflected concepts—generate problems. Therefore, clients must develop novel concepts—ideas about what is possible—to derive new actions that enable more learning.

The practitioner listens attentively to the client and asks questions. Therapists use solution-oriented questions, exception questions, outcome questions, scaling questions, and relationship questions to assist the client in defining the preferred reality (Lee, 2013, p. 5). These questions fully utilise the potential and resources of the clients (Berg & Kelly, 2000; De Jong & Berg, 2013; de Shazer et al., 2007). Questions effectively achieve such a task as they open the conversational space for clients to self-assess themselves and their situations.

SFBT sessions tend to be more collegial than hierarchical and cooperative rather than adversarial, even though SFBT therapists lead one step from behind (Trepper et al., 2014, p. 4). Therapists generally assume that most people have the strength to make the necessary progress and that everyone has already solved multiple problems. Sometimes, clients can repeatedly deploy these solutions without inventing anything new. In the case of not having a previous method, we assume that every issue has exceptions that can be uncovered and benefitted from.

To no surprise, SFBT therapists use questions as their primary form of communication with the client; they rarely directly challenge or confront the client (Trepper et al., 2014, p. 5). SFBT therapists tend to make no interpretations of the client's responses and generally accept the client's reality.

When clients progress, the SFBT therapist focuses their attention on the conversation by giving compliments (Trepper et al., 2014, p. 5). Therapists achieve this by directly expressing the praise or posing a question inviting the client to compliment herself, such as "What do you think about such an achievement?"

Some of the primary active constituents of SFBT are:

- A cooperative therapeutic alliance with the client;
- Creating a solution instead of analysing a problem;
- The setting of measurable changeable goals;
- Focus on the future through future-oriented questions and discussions;
- Scaling the ongoing attainment of the goals to get the client's evaluation of the progress;
- Focusing on the exceptions to the problem;

(Trepper et al., 2014, p. 4)

Pre-session change

Early in the therapeutic process, the therapist helps the client to notice changes in her life. Here lies the assumption that the client initiates change, not the therapist, and that change is an ongoing process that clients can utilise. The therapist asks, "What changes have you noticed that have happened or started to happen since you called to make the appointment for this session?" (de Shazer et al., 2007, para. 10.45; Trepper et al., 2014, p. 5). Such a question indicated that change is always happening or that no problem happens constantly. SFBT therapist, therefore, takes the chance to inquire about a possibility of change already happening. There are just several types of answers one might receive from a client.

Here is an example of asking for a pre-session change in a therapeutic setting:

T: What has improved since you decided to come here?

C: Well, I started thinking I might improve my life.

T: You started thinking that you might improve things; how did you manage to do that?

C: I talked to my partner and realised I could at least try.

T: What else did you do to start thinking you might improve things?

C: I started doing sports again and saw my sister more frequently.

The client might say that nothing has changed; in this case, there is not much to inquire about, and the therapist will usually continue with another question, asking, e.g. "How can I be helpful today?" (Trepper et al., 2014, p. 5). In some instances, the client will say that some things have improved. This answer signals to the therapist that there is a potential to elicit details about what has happened and, more importantly, what has been done by the client to achieve that.

Possibly, the client might say that things have gotten even worse since she made the appointment. In this case, the therapist will elude the problem analysis by avoiding questions such as "What is the problem?" or "Why did that happen?" A skilful way to prevent such a talk is to ask the client how she managed the situation. Here another assumption is apparent: the client has managed to come to the session, so she must have done something to achieve this. No matter how much the situation has worsened, the client has done something to continue.

Ideally, the client answers that something has improved; in such a case, the "solution-talk" starts, and the therapist elicits as much detail as possible to identify behaviour that has proven helpful to the client (Trepper et al., 2014, p. 6).

Solutions as goals

In SFBT, therapists expect clients to frame specific and achievable goals. Clients communicate these goals as solutions rather than an absence of a problem (de Shazer et al., 2007, para. 10.49). Therapists assume no direct relation between the problem and the solution. Clients can create solutions without a detailed understanding of the problem. The client is encouraged to frame the goals as straightforwardly as possible, providing many details in their descriptions. Importantly, therapists ask the clients to affirm their goals, i.e., describing what they desire rather than what they want to avoid (Trepper et al., 2014, p. 6).

If a client defines her desire as eliminating the problem, it is still not clear what the goal is. One might imagine a situation where a taxi driver asks the client, "Where would you like to go?" and the answer would be ", I do not want to go to the city centre." It is obvious where we do not want to go in this case. Unfortunately, it is insufficient to provide us with information about the destination. Therefore, we are looking for descriptions of the desired state. Sometimes clients might think that eliminating a problem is the desired state. But such an idea is analogous to the example mentioned above. Here is an example of negotiation of a therapeutic goal:

T: What are your hopes for our work together?

C: I have huge problems in my private life, so I hope to get rid of these problems.

T: What would you like to have instead of these problems?

C: I want to eliminate these problems, so I hope we can discuss them here.

T: How would you know this talking here was useful?

C: If my life would be better!

T: How would you know your life was better than before?

C: If I had a calm and stable relationship with my partner, I would already know that my life has improved.

T: You want a calm and stable relationship with your partner. How could today's conversation help achieve that?

C: I want to know what the problem is between the two of us.

T: If you knew that, what difference would it make?

C: I could then think about what to change.

T: So, you would like to know what to change?

C: Yes.

T: How would you notice at the end of today's conversation that you know it?

C: If I had at least three ideas to try out.

T: So, you would like to have at least three ideas to know what to change to have a calm and stable relationship with your partner. Would that be what you came for today?

C: Yes.

Miracle questions

Probably the most famous method coming from the SFBT is the Miracle question. Some clients have difficulties framing their therapeutic goal as they immerse themselves in the problem-talk, the Miracle question is a helpful tool to overcome such problems, and at the same time, it serves as a virtual rehearsal to "experience" the desired outcome (Trepper et al., 2014, p. 6).

The Miracle question allows the client to separate themselves from the problem-saturated present or past and define a problem-free future. The main focus is identifying small, concrete, observable steps that can make a difference in the client's life (De Shazer, 1985). It is an exciting move in the conversation as it incorporates miraculous aspects to achieve its purpose. Berg and Dolan state that the miracle question can have the following form:

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

The miracle question is not the only SFBT method to elicit vivid descriptions—there is the Dream question (Greene et al., 1998) or the Nightmare question (Reuss, 1997), which both serve different purposes. What clients express as the answer to the Miracle question can usually be taken as the goals of

the therapy (Trepper et al., 2014, p. 8). Therapists can use the Miracle question in individual, couple, family, or group sessions.

Scaling progress

Another critical method in the SFBT is the scaling question. This type of question is a valuable tool—it helps the client evaluate their progress (Trepper et al., 2014, p. 9). Scaling questions ask the client to rank their current situation on a scale of 1 to 10 (De Jong & Berg, 2013). Usually, 10 represents the best, and 1 or 0 the worst times. They provide a simple tool for clients to rank themselves and their progress against the goal of the therapy. Therapists can use Scaling questions for different purposes—one can scale the client's progress whereas another one is directed towards confidence to improve. Below you can find both types:

- On a 1-to-10 scale, with one being the worst problem and ten as the most desirable outcome, where would you put yourself on the scale?
- On a 1-to-10 scale, with one being you don't believe you can do anything to change the situation and ten being determined to change the problem, how would you put yourself on the scale? What would your wife say using the same scale?
  (Lee, 2013, p. 6)

Scaling questions are instrumental as they put a frame around the session and also the client's progress. The therapist will ask the client to assess their state when they have made the appointment, their current state and the hypothetical state after the miracle has happened on a scale from 0 to 10 or 1 to 10 (de Shazer et al., 2007, para. 10.57). An important thing to understand is that the scaling question acts as a platform for the following part of a session. The scaling question itself does not bring any value. It would be naïve to expect that asking the client, "Where are you right now?" and not using the answer anyhow would bring any benefit.

The scaling question aims to open up a solution-focused space so we can keep going in the direction fundamental to the SFBT. A client might feel that the day after the miracle is a 10. The therapist will then follow up with a question such as "And where would you put yourself right now?" the client might say, "Just a three." Unsurprisingly, this is not a problem for the SFBT therapist as she will continue by asking, "And what makes it a three and not lower?" again to elicit more details about what is working rather than what is not.

The scaling questions are later used in the following sessions to measure progress (de Shazer et al., 2007, para. 10.70). This tells us more about how the client's progress therapists perceive the client's progress in the SFBT. It illustrates the therapist's role even more as it shows us that the client is the expert in the matter, and the therapist is not there to judge or assess the client. If the client believes she has made substantial progress, the therapist has no reason to challenge such a belief. The therapist is more of a partner in the process than a leader. More importantly, the relationship between the client and the therapist develops throughout the therapeutic process—it is not a separate phase. This equal relationship

encourages the client to identify prospective ways to progress. The methods that the therapist uses are then mere manifestations of this partnering.

When scaling the current state, there are not many types of questions that a therapist might utilise. That is also the reason for the above statement: the scaling questions provide a frame for the session. One of the possible answers to a scaling question is that the current state is 10 out of 10. In this case, the therapeutic process finishes, and the therapist might end the session with the client by asking questions such as “So what else would you like to talk about?” or “What have you learned now that you have achieved this?”

Another possible answer might be that the client says she is in a lower position than the number representing the day after the miracle. This answer is the most frequent one—it happens during the main body of the therapeutic process. In this situation, there are two possible directions for the session. One approach is to inquire about the client's resources. A question might be, “And what makes it a (the number) and not lower?” probing the client to explain what is already there—what is already working so it’s not the lowest possible mark. The therapist will then continue eliciting more detail about the client’s resources by asking what the client has done to make it happen. The purpose of such questions is to permanently identify the specific behaviour that the client exhibits to achieve these results. Identifying these behaviours helps the client solidify them and raises the probability of repeating or using them.

Another direction to take is to ask what the client would notice in her life if she moved just one notch higher on the scale. When the client says she is on a 3, the therapist might ask, “And what would you notice if you were at a 4?” Such a question aims to help the client identify minor signs representing progress. This method illustrates the general assumption in SFBT that if clients verbalise no observable signs of improvement, we cannot progress. As we do not know how clients would notice progress, we cannot realise it has occurred. Such an assumption is an example of a strong influence of Wittgenstein as he stated, “An inner process needs outward criteria.” (1968, para. 580) We can trace this assumption throughout the whole SFBT approach. Therapists constantly demand to specify outward criteria when referring to internal mental states. The reason is simple: if the client later thinks she has not made any progress, how can she know that? How is one to tell? Can a feeling serve to measure such a matter? Imagine that client comes into the session and says, “Today I feel the same as last time,” the question then is “, How can she tell if it is so?” and the somehow intuitive answer might be “, Of course, by a feeling.” But how would that work in practice? Would the client focus on her feelings and make the judgment based on the feeling she has right now? There seems to be no problem with that, as this is how we ordinarily do it. We ask ourselves how we feel today, focus on our feelings and then give ourselves an answer.

But in this particular case, a comparison is necessary. How do I arouse the feeling of the feeling I had last time? Do I call it out from memory? And what form does it have when I call it out? Is it a feeling or a description of that feeling expressed in words? But how would I know that I have remembered it correctly? And if I have recalled the feeling by directly experiencing it, how would I compare it to the feeling I have right now? Where would I put the current feeling? Or would I have the present feeling simultaneously with the recalled one? And what would be the output of such an assessment? Would that

be feeling? So, then it would have to be a comparison of feeling from memory with a feeling of the current state. Something that sounds improbable to execute appropriately.

The last type of answer is that the client says she is at the lowest possible notch—possibly a one or a 0, depending on the scale we used in our question. In this case, a "coping question" comes into play. When clients report that things are at their worse, the SFBT therapist will continue in the solution-focused direction. It might seem impossible in such a scenario, but there is a way to accomplish it, and that is the coping question. The coping question might appear in the form "And how are you coping with it?" the client might start providing some details about what she is doing and how she is dealing with the situation even though the problem is severe.

In some cases, what might happen is that the client answers that she is not dealing with it anyhow and that things are getting worse. Even in such a case, the SFBT therapist will continue the session in the solution-focused direction. This advancement, again, might seem almost impossible. Still, another version of the coping question becomes handy, "And what are you doing so that things do not get worse even faster?" would be another way of using the coping question. Even if the client then says, "I am not doing anything", the therapist might keep inquiring ", So how come you have managed to come to the session?" All the questions mentioned above are highly dependent on the context, and it is not a process that every therapist will follow on every occasion.

Exception questions

The SFBT therapist spends most of the time listening attentively, waiting for solutions, exceptions, and goals—clients express them. When this happens, therapists inquire about them to elicit more detail (Trepper et al., 2014, p. 10). Such inquiry requires a different skill set than the one needed in other problem-focused therapeutic models.

Exception questions inquire about times when the problem is absent, less intense, or dealt with in a way acceptable to the client (De Shazer, 1985). The therapist assumes that change is happening in the problem pattern and that there must be times when the problem is "at its best". Exception questions aim to discover those moments and elicit further details that clients can utilise. Such questions challenge clients' usual rigid frame of the session, making their problems persistent and permanent. Examples of exception questions include:

- When was the last time that you didn't have this problem?
- When was the last time you expected that you'd have the problem, but it did not happen?
- When was the last time that you thought you would lose your temper, but you didn't?
- What was different about these times?

(Lee, 2013, p. 6)

An exception to the problem is an integral part of the SFBT. What distinguishes the SFBT from other problem-focused therapies is that the SFBT therapist will listen attentively for the signs of previous solutions, exceptions, and goals instead of focusing on what is causing or maintaining the problem (de

Shazer et al., 2007, para. 10.95). For example, the client might mention that her relationship with her husband is getting worse and worse; they cannot even talk to each other like they used to before. An intuitive way forward is to inquire about what is wrong or not working—something an SFBT therapist does not do.

Instead, the SFBT therapist will listen with a *constructive* ear and identify parts of the session that might lead to a solution-focused talk. "And you said that you used to talk to each other before. When was the last time this has happened?" might be a potential question from the therapist. To be precise, such a question is no longer an exception question—it does not inquire about an exception to the problem. These questions result from the recent development of SFBT (McKergow, 2020). To make the session even more solution-focused, the therapist will inquire about instances of the preferred future already happening rather than an exception to the problem. Thus, such a question is not exploring exceptions but instances—this allows the client to focus on the desired outcome without encouraging problem analysis.

When asked in such a way, the client is encouraged to think about the last time things were working. The therapist will then proceed to elicit more details about those times, asking potentially about every detail, inquiring how the client achieved it, and every possible action the client took to have matters in such a state. The reason for asking these questions might not seem obvious. Still, it is the assumption in SFBT that clients create solutions by identifying what already works and what they are capable of rather than talking about what is missing and what they are doing wrong. The client might identify multiple elements in the above example when things were working fine. This information can serve the client well, opening possibilities and new ideas about what the client might attempt as a change.

Here is an example of a conversation where an inquiry about instances occurs:

C: I need to be more confident when I deal with him!

T: When was the last time you were confident dealing with him?

C: That was a long time ago.

T: And how did you manage to do so?

C: I gave it some preparation. I wrote down what I wanted to say; then expressed it without justifying myself.

T: What else did you do?

C: I met him at a neutral place.

T: What place was that?

C: A restaurant he did not know.

T: So you wrote down what you wanted to say and met him at a place he did not know.

C: Yes.

T: How could that be useful to you?

Coping questions

I have already described the coping question as a possible solution-focused method. When clients report that things are challenging, the therapist might sometimes ask, "How are you coping with that?" (Trepper et al., 2014, p. 12); by this, she manages to keep the conversation about strengths. Coping questions help clients identify when they are dealing with the problem and understand their actions to achieve that (Lee, 2013, p. 6). Coping questions reframe clients' reality when they assume they have no control over their problems (Berg & Steiner, 2003). Examples of coping questions include:

- How have you kept going despite all the difficulties you've encountered?
- How are you able to get up despite being so depressed? A newly developed question is the "lemon question" that embraces personal pride and dignity in assisting clients to look for individual strengths in coping with a difficult situation: Suppose you came to see, with new clarity, that _____ [a normalised statement of the problematic life predicament in which the clients find themselves], what would you be most proud of as your response to that situation? (Lee, 2013, p. 6)

The assumption behind this question is that the client must have done something to achieve that she has somehow advanced to the therapeutic session. The coping question can manifest in multiple forms. In general, the therapist will ask about what the client is doing and how the client is managing or coping with the difficult situation. If the client replies with a negative answer, the coping question can appear in another form, such as "What are you doing to stop things from getting even worse?"

A coping question is a handy tool as it is a necessary part of the solution-focused repertoire, especially when clients report that things are at their worst. The purpose of coping questions is to maintain the session's direction toward solutions and keep talking about what is already working rather than what is not.

There is a subtle difference between using the word "coping" and "managing" in the therapist's inquiry. The therapist can ask the client, "How are you managing that?" primarily if the client is not at her worst, whereas the coping question is available anytime the client is struggling with something. The managing version aims to elicit descriptions of what the client is doing to achieve something or keep it as it is. The coping version is directed more towards exploring strengths when it seems the client is experiencing a deterioration of her situation.

Relationship questions

Relationship questions ask the client to imagine how their significant others would react to them if they were achieving their goals or making progress (De Jong & Berg, 2013; De Shazer, 1994). These questions build on the assumption that problems are relational phenomena, i.e., people are not isolated individuals but individuals in a complex network of other individuals. Such questions do not necessarily just put context to the problem definition but add context to the desired goals and minor signs of progress.

Furthermore, they help enrich the descriptions as they elicit different signs to look for as indicators of progress in real life. Examples of relationship questions include:

- Who would be the first to notice changes in you?
- What would your friends notice that is different about you if you are more comfortable with the new college environment?
- How would your mother rate your motivation to do something different and helpful on a 1-to-10 scale?
  (Lee, 2013, p. 6)

Relationship questions commonly link a chain of interactions (Iveson, Ratner, et al., 2012). During these inquiries, the therapist encourages the client to explore how others would react to specific events and what other reactions this would trigger in the client and other individuals.

Tasks and experiments

SFBT regularly used tasks to help clients notice solutions in their everyday life (de Shazer & Molnar, 1984; Molnar & de Shazer, 1987). Such assignments may have the following form:

- If clients can identify exceptional behaviours to the problem, then clients are asked to "do more of what works." (Lee, 2013, p. 7)
- For clients who focus on the perceived stability of their problematic pattern and fail to identify any exceptions, an observation task is given: "Between now and the next time we meet, we (I) want you to observe so that you can tell us (me) next time, what happens in your (life, marriage, family, or relationship) that you want to continue to have happened" (Molnar & de Shazer, 1987)
- Do something different ("Between now and next time we meet, do something different and tell me what happened") and the prediction task, which asks the client to predict their behaviour by tossing a coin ("If it is "heads", do what you normally do; if it is "tails", pretend that the miracle day has happened") (Lee, 2013, p. 7)

Tasks should build on something the client is already doing, e.g., the exceptions to the problem (Trepper et al., 2014, p. 12). SFBT therapists assume that clients are more likely to do something they are already familiar with. A client can design her homework assignment, increasing the probability of successful completion.

Recent development in the SFBT reveals an essential change in crafting tasks: clients are no longer encouraged to construct tasks but experiments (McKergow, 2020). The crucial difference between the two is that a task is an activity to achieve the desired outcome. In contrast, an experiment is an activity clients design to learn something. By encouraging clients to formulate experiments, the therapist implicitly communicates an assumption entailed in the everyday use of an experiment: let us try something so we can learn if our hypothesis is correct. The benefit is that the client approaches the activity expecting it might not lead to the desired outcome—but this is not the sole purpose. The purpose

of an experiment is not to induce a result but to learn something; when clients execute an experiment, new learning will emerge for the client. This arrangement helps the client avoid disappointment because the focus is not on a specific outcome but on knowledge acquisition.

Second session and more

When the therapy progresses into the following sessions, the solution-focused way to open a session is to inquire about what has improved. Typically, the therapist will ask about what has been better. Many clients will report that some things have improved (Trepper et al., 2014, p. 13).

After the first one, the focus of the sessions is to facilitate clients to notice changes between the sessions (Lee, 2013, p. 7). A typical question is the "What's better?" question, which can be asked in a way such as "So what is better, even a little bit, since the last time we met?" (Trepper et al., 2014). Noticing that something has changed is an essential step for the client. Another critical task for the therapist is to help the client understand how their actions relate to their achieved goals. The therapist asks questions such as "How were you able to do that?" or "What have you done to achieve that?" (Lee, 2013, p. 7).

It is not uncommon that clients do not do the tasks they have agreed with the therapist, or they do not report any significant progress. Therapists do not perceive such a situation as good or bad, but they take it as feedback to continue co-constructing the solution with the client (Lee, 2013, p. 8). The responses are not judged or analysed for other purposes; they are just feedback (De Shazer, 1985). The key for the therapist is to stay persistent and patient (Lee, 2013, p. 7). People need to experiment to find what is helpful to them. When clients do not report any change, the reason might be that the tasks or goals are irrelevant; otherwise, they would motivate them to do something. The therapist should continue providing options to the client and help them to try something different; she should not view the client as resistant but instead look for ways of cooperating (Lee, 2013, p. 7).

The therapist needs to refrain from suggesting a solution. She should focus on providing therapeutic dialogue in which the client can find what works for her in her unique life context. Presumably, therapists can achieve it by asking questions such as "How are you doing?"; however, this would not lead to solution-focused talk. Therefore, the usual way to start is by asking "What's better?" to specifically inquire about the improvement rather than about how it is going in general (de Shazer et al., 2007, para. 13.80). Such a question invites the client to describe everything that she thinks has improved but does not open the conversation space too much so that the client might start describing the problem.

The types of answers a therapist might receive are similar to the ones I have already mentioned. To summarise, if the client shares improvements, then the goal of the therapist becomes to identify the behaviour that has caused these improvements. Suppose the client does not report any progress. In that case, the therapist might continue the session or ask a coping question to elicit more details about something already working in the client's life. The last option might be that the client shares that things are getting worse; in this case, a different form of the coping question, such as "What are you doing so that things are not getting worse even faster?" might serve as the last option.

It is also possible to use the scale in the following session by asking where the client has been on the scale, with ten still representing the day after the miracle (de Shazer et al., 2007, para. 13.81). When the client answers, the therapist can ask what was different when the number was higher and elicit more detail.

Conclusions and potential implications for practice

SFBT is one of the most popular and widely used therapy models in the world—it emphasises clients' strengths, resiliency, previous solution, and exceptions to problems. Therapists deploy SFBT for various issues (de Shazer et al., 2007, para. 10.149). Examples include family therapy (McCollum & Trepper, 2001), couple therapy (Weiner-Davis, 1992), treatment of sexual abuse (Dolan, 1991), substance abuse (Berg & Miller, 1992; Shazer & Isebaert, 2004), and also as a treatment of schizophrenia (Eakes et al., 1997). The solution-focused approach proved its versatility—practitioners apply it in other non-therapeutic settings. These include self-help books (Dolan, 2000), intervention in social services (Pichot & Dolan, 2013), education (Rhodes & Ajmal, 2004), business organisation (Cauffman, 2001), personal coaching (Iveson, George, et al., 2012), team coaching (Burgstaller & Iveson, 2019), and organisational development (Jackson & McKergow, 2007; McKergow & Bailey, 2014).

Professionals listed SFBT in the Office of Juvenile Justice and Delinquent Prevention Model Program Guide and SAMHSA's National Registry of Evidence-based Programs and Practices (Lee, 2013, p. 10). Also, the book "Solution-focused brief therapy: A Handbook of evidence-based practice" confirms SFBT's validity (Franklin et al., 2011). These are all critical milestones for SFBT—its history is not as rich as other well-established approaches like cognitive behavioural therapy.

SFBT is a recognised psychotherapeutic approach in the Czech Republic—the Czech Association for Psychotherapy accredits SFBT training (Česká asociace pro psychoterapii, 2023). The accredited training adheres to the Czech Association for Psychotherapy standards. A graduate of the training is competent to conduct her independent practice of the psychotherapeutic profession according to the standards of the European Association for Psychotherapy (European Association for Psychotherapy, 2023). Aspiring therapists interested in educating themselves in SFBT are encouraged to search for accredited training on the Czech Association for Psychotherapy website. Those who are interested in attending a therapeutic session can search for an accredited therapist on the website of the Czech Society of Psychotherapy (Česká psychoterapeutická společnost, 2023).

Summary

In this article, I have explored the main solution-focused methods. The purpose of all of them remains similar: support the client in the solution-focused talk. This talk is specified by focusing on the aspects of the client's life that are working, focusing on the client's strengths, and identifying exceptions to the problem. The therapist's role is to identify signs of these aspects in the session and gently steer the attention toward a discussion about them.

References

Berg, I. K., & Dolan, Y. M. (2001). *Tales of solutions: A collection of hope-inspiring stories*. Norton.

Berg, I. K., & Kelly, S. (2000). *Building solutions in child protective services* (1st ed). Norton.

Berg, I. K., & Miller, S. D. (1992). *Working with the problem drinker: A solution-focused approach*. W.W. Norton.

Berg, I. K., & Steiner, T. (2003). *Children's solution work* (1st ed). Norton.

Biro, J., & Kotatko, P. (Eds.). (2013). *Frege: Sense and reference one hundred years later* (Reprint). Springer Science+Business Media.

Burgstaller, S., & Iveson, C. (2019). *Team Talk: Building Excellence with Solution Focused Skills*. Usolvit.

Cauffman, L. (2001). Challenging the family business: The relational dimension. *Scandinavian Journal of Organisational Psychology*, 11.

Česká asociace pro psychoterapii. (2023, May 10). *Česká asociace pro psychoterapii, z.s. - Certifikované výcviky*. https://czap.cz/Certifikovane-vycviky/

Česká psychoterapeutická společnost. (2023, May 10). *Česká psychoterapeutická společnost ČLS JEP*. https://www.psychoterapeuti.cz/

De Jong, P., & Berg, I. K. (2013). *Interviewing for solutions* (4th ed). Cengage Learning.

De Shazer, S. (1985). *Keys to solution in brief therapy* (1st ed). W.W. Norton.

De Shazer, S. (1994). *Words were originally magic* (1st ed). W.W. Norton.

de Shazer, S., Dolan, Y. M., & Korman, H. (2007). *More than miracles: The state of the art of solution-focused brief therapy*. Haworth Press.

de Shazer, S., & Molnar, A. (1984). Four useful interventions in brief family therapy. *Journal of Marital and Family Therapy*, *10*(3), 297–304. https://doi.org/10.1111/j.1752-0606.1984.tb00020.x

Dolan, Y. M. (1991). *Resolving sexual abuse: Solution-focused therapy and Ericksonian hypnosis for adult survivors* (1st ed). Norton.

Dolan, Y. M. (2000). *One small step: Moving beyond trauma and therapy to a life of joy*. iUniverse.

Eakes, G., Walsh, S., Markowski, M., Cain, H., & Swanson, M. (1997). Family centred brief solution-focused therapy with chronic schizophrenia: A pilot study. *Journal of Family Therapy*, *19*(2), 145–158. https://doi.org/10.1111/1467-6427.00045

European Association for Psychotherapy. (2023, May 10). *European Association for Psychotherapy | EAP | Welcome*. European Association for Psychotherapy. http://www.europsyche.org/

Franklin, C., Trepper, T. S., McCollum, E. E., & Gingerich, W. J. (2011). *Solution-focused brief therapy: A handbook of evidence-based practice*. Oxford University Press.

Greene, G. J., Lee, M.-Y., Mentzer, R. A., Plnnell, S. R., & Niles, D. (1998). Miracles, Dreams, and Empowerment: A Brief Therapy Practice Note. *Families in Society*, *79*(4), 395–399. https://doi.org/10.1606/1044-3894.701

Iveson, C., George, E., & Ratner, H. (2012). *Brief coaching: A solution focused approach*. Routledge.

Iveson, C., Ratner, H., George, E., & ProQuest (Firm). (2012). *Solution focused brief therapy 100 key points and techniques*. Routledge.

Jackson, P. Z., & McKergow, M. (2007). *The solutions focus: Making coaching and change simple* (2nd ed). Nicholas Brealey International.

Lee, M. Y. (2013). Solution-Focused Brief Therapy. *Encyclopedia of Social Work*. https://doi.org/10.1093/acrefore/9780199975839.013.1039

McCollum, E. E., & Trepper, T. S. (2001). *Family solutions for substance abuse: Clinical and counseling approaches*. Haworth Clinical Practice Press.

McKergow, M. (2020). SFBT 2.0: The next generation of Solution-Focused Brief Therapy has already arrived. *Journal of Solution Focused Practices*, *2*(2), 18.

McKergow, M., & Bailey, H. (2014). *Host: Six new roles of engagement for teams, organisations, communities and movements*. Solutions Books.

Molnar, A., & de Shazer, S. (1987). Solution-focused therapy: Toward the identification of therapeutic tasks. *Journal of Marital and Family Therapy*, *13*(4), 349–358. https://doi.org/10.1111/j.1752-0606.1987.tb00716.x

Pichot, T., & Dolan, Y. M. (2013). *Solution-focused brief therapy: Its effective use in agency settings*. Routledge.

Reuss, N. H. (1997). The Nightmare Question. *Journal of Family Psychotherapy*, *8*(4), 71–76. https://doi.org/10.1300/J085V08N04_06

Rhodes, J., & Ajmal, Y. (2004). *Solution focused thinking in schools: Behaviour, reading and organisation*. BT Press.

Russell, B. (2010). *The philosophy of logical atomism*. Routledge.

Shazer, S. de, & Isebaert, L. (2004). The Bruges Model. *Journal of Family Psychotherapy*, *14*(4), 43–52. https://doi.org/10.1300/J085v14n04_04

Trepper, T., Mccollum, E., Jong, P., Korman, H., Gingerich, W., & Franklin, C. (2014). *Solution-focused therapy treatment manual for working with individuals*. https://doi.org/10.4135/9781483352930.N2

Weiner-Davis, M. (1992). *Divorce busting: A revolutionary and rapid program for staying together*. Summit Books.

Whitehead, A. N., Russell, B., & Whitehead, A. N. (1997). *Principia mathematica* (Pbk. ed). Cambridge University Press.

Wittgenstein, L. (1968). *Philosophical investigations*. Basil Blackwell.

About author

Tomáš M. Zídek, a devoted PhD student at Charles University, is investigating the interplay between solution-focused brief therapy and philosophy of language, inspired by Wittgenstein, Sellars, and Brandom. His research illuminates how language impacts therapeutic processes, while his active participation in academic discourse contributes to the broader scholarly community. Zidek's work promises to influence future research on the connection between language, thought, and behavior.
Contact: Department of Philosophy and Religious Studies, Charles University, Prague, CZ
E-mail: zidekt@ff.cuni.cz

Zídek, T. M. (2023). Solution-focused therapeutic methods. *E-psychologie*, 17(2), 41-57. https://doi.org/10.29364/epsy.468