Is Solution-Focused Brief Therapy Different?

In a recent conversation, a cognitive behavioral therapist said, "I know what SFBT is. It's CBT with scales." Another therapist said, "Anything that works is solution focused." A third one said, "I did solution focused therapy long before I heard of it. I've always tried to find solutions." And the fourth one said, "Solution focused is no different from systemic therapy."

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Well, everyone is entitled to their opinion, and our opinion is not an essential truth. We have observed—over more years than we care to remember—that what happens in an SFBT session is very different from what happens in sessions with therapists of other persuasions. So, how is it different? Specifically, what do therapists and clients do in an SFBT session that is not happening in other therapy sessions? And, perhaps more importantly: What do therapists and clients ***not*** do in an SFBT session that is happening in other therapy sessions?

Looking Closely at an SFBT Dialogue

Because SFBT is fundamentally about therapeutic dialogue, the best way to answer these questions is to examine an SFBT dialogue, along with descriptions of the therapist's typical moment-by-moment choices. This 1.27-minute excerpt from the beginning of a first session is unedited, with the natural overlapping and hesitations included, and only potentially identifying information edited out. The therapist is Harry Korman.

1. **Korman:** So, um. Is it okay if we start like, uh *[pause]*. What will have to happen, as a result of you *[gestures toward her]* coming here today—this afternoon, tomorrow, the day after tomorrow—for you to feel that it's been somewhat useful to, to be here?

The therapist's opening question operates at two levels. It is explicitly a request for information ("What will have to happen . . .?") but, like any question, there are also *implicit presuppositions* (McGee, Del Vento, & Bavelas, 2005). Presuppositions are the questioner's assumptions that frame the question. Here, the question presupposes that (a) something could happen as a result of her coming here today; (b) it could happen this afternoon, tomorrow, or the day after tomorrow; (c) when this happens, it will make her feel that it's been somewhat useful to be here; (d) she is able to know and to articulate what she wants to have happen as a result of the therapy session.

In all questions, the presuppositions orient the client to certain aspects of his or her experience; here, the possibility of a "somewhat useful" outcome of the session. What an SF therapist would not do is to start with a series of detailed questions about the problem that brought the client to therapy (e.g., an assessment of behavioral and/or emotional problems, the family structure, adjustment disorder, distressing thoughts, or distorted thinking).

Perhaps the most important feature of any question is that, in answering the question, the client usually cooperates with, and therefore implicitly accepts, the therapist's presuppositions. Answering questions with SF presuppositions can itself produce change (Richmond, Smock Jordan, Bischof, & Sauer, 2013). Because

all questions, in any therapy, present implicit presuppositions, SF therapists craft their questions extremely carefully. These questions often seem quite odd to other therapists because SFBT presuppositions focus on what clients want to have happen in their lives, their resources, and their competencies, rather than their problems.

A single question doesn't define a model. Far from it. In this excerpt, the client does not answer right away:

2. **Client:** Um.

3. **Korman:** *[Remains silent and settles into a listening posture, one hand holding his chin, looking directly at client.]*

4. **Client:** I don't think I'm—*[laughs, then gestures toward therapist with a slight shrug]*

5. **Korman:** *[nods]* It's a difficult question. *[gestures and returns to a listening posture]*

6. **Client:** *[overlapping]* — am even looking that far ahead. *[looks down]* Um. *[long pause]*

7. **Korman:** *[stays in listening posture, remains silent]*

The therapist does not rephrase or change his opening question, nor does he offer any interpretation of why she might be hesitating (e.g., her emotional state, her inability to answer). Instead, he attributes her hesitation to the question, labeling it as "a difficult question," which implicitly explains her struggle and even credits her for trying.

Then, as she begins to articulate answers, he nods vigorously and makes notes, even though she describes more problems than something "somewhat useful" that could happen:

8. **Client:** I don't know, I-I guess—maybe just to *[pause]* sort together everything I'm—

9. **Korman:** *[overlapping: tilts head to the right as if more interested, then poises pen to write]*

10. **Client:** —feeling. I don't exactly know what that is yet.

> **"Because all questions, in any therapy, present implicit presuppositions, SF therapists craft their questions extremely carefully."**

11. **Korman:** *[overlapping: nodding slowly, looks down and writes briefly and then looks back up at client keeping pen on pad]*

12. **Client:** I don't...*[gestures with left hand towards the therapist]*

13. **Korman:** *[overlapping: nods]*

14. **Client:** I don't exactly know what's bothering me, like– I mean I–

15. **Korman:** *[overlapping: nods continuously]*

16. **Client:** I'm in the process of going through a divorce, so–

17. **Korman:** *[Overlapping: Looks down to paper and writes briefly. Slightly overlapping with client finishing: makes a vigorous nod]*

18. **Client:** I'm sure that's *[gestures toward him with both hands and then puts them on lap]* the majority of it.

19. **Korman:** *[Overlapping start as he puts down her hands (this makes a small sound): looks up at her, then]* Mm, Mm. *[while nodding]*

20. **Client:** Just recently I haven't been able to sleep too well, 'n—*[pause]*

21. **Korman:** *[Overlapping: looks down, writes and nods]*

Then she returns to what she said in #8, which begins to answer his initial question:

22. **Client:** So I thought maybe this might—*[pause]* help me sort out whatever I need to— *[while speaking, gestures between herself and him]*

23. **Korman:** *[Overlapping: looks up at her as she says "might," then down to his notes. Nods and says:]* Right.

24. **Client:** —to get my life back together. *[smile and slight laugh]*

25. **Korman:** *[Looking down and writing as he talks:]* Help you sort something out to get your life together. *[Then nods and looks up at her; slight pause]*

So far, in answer to his question, she has told him that she

- doesn't think she is even looking that far ahead; doesn't know [how to answer]
- guesses maybe she wants to sort together everything she's feeling but doesn't know exactly what that is yet
- doesn't exactly know what's bothering her
- is in the process of going through a divorce, and she's sure that's the majority of it
- hasn't been able to sleep too well just recently
- thought that [therapy] might help her sort out whatever she needs to get her life back together.

The entire sequence so far illustrates a central part of the co-constructive process that underlies all therapies, a process that De Jong and Berg (2013) called "Listen, Select, Build." The therapist *listened* to what the client was saying, *selected* what she was describing as useful to her, and then *built* on these parts (in #25). That is, out of everything she had said to him, the therapist selected "help you sort something out to get your life together." Therapists call this kind of response echoing, paraphrasing, summarizing, etc. Most therapists see these responses as simply showing that they are listening and not as directly influencing the client. In the research

literature, the term for these responses is *formulation*, and closer analysis shows that formulations are always selective and influential (Korman, Bavelas, & De Jong, 2013). Notice what his formulation does and does not select: it uses her exact words about how therapy could be useful and does not mention her uncertainty, divorce, or sleep. It is building in a certain direction. In different kinds of therapy, the therapist would have selected those problem topics, perhaps rephrased in technical terms such as "grief," "loss," "distress," "depression," and/or "insomnia." Those choices would build in a different direction (Smock Jordan, Froerer, & Bavelas, 2013).

After his formulation, the therapist immediately follows up with a more specific version of his first question. Having selected the possibility that "getting her life together" would be something useful for her, he builds on this by asking how she would know this would be happening:

25. **Korman:** (continued) *[slight pause, then asks, while gesturing frequently toward her:]* So—what would be a feeling, ah, a thought, an action, something you would do or think or feel [slight pause] that would tell you that you were sort of getting your life together? *[keeps looking at her]*

26. Client: Umm—*[pause]*

27. Korman: —this afternoon or tomorrow? *[then looks down and places pen as if to start writing; looks up and tilts his head as soon as she starts to speak]*

28. Client: I guess like—just, relaxing maybe *[gestures toward him]*.

29. Korman: *(big nod, looking down and writing:]* Relaxing.

This final sequence of the excerpt includes both the therapist's and the client's contributions, illustrating clearly how co-constructing works. His question closely paraphrases her answer at #24 ("to get my life back together"), and it adds the presupposition that she would "do or think or feel" something that would tell her that this was "sort of" happening." She provides an answer (#28) that is unique to her. He formulates her answer by selecting only the concrete, behavioral, specific part ("relaxing") and omitting all of the qualifiers ("I guess like, just...maybe"). Thus, the opening 1½ minutes of the session illustrates the observable process of co-construction in which the client and therapist collaboratively contributed to a continually evolving version, from her current problem-saturated life to the beginning of a description of one step toward a more hopeful preferred future.

SFBT Does Not Focus on the Problem

We find it curious that even those therapists who reject everything else about the medical model have still retained such a strong belief in diagnosis as the key to treatment; that is, a conviction that it is necessary to know (or hypothesize) the cause of the problem in order to solve it. This logic makes sense for physically verifiable problems, such as diabetes. However, a clear link between problem and solution is questionable in areas such as psychotherapy where the diagnosis cannot be directly verified, and any underlying cause of the problem is, strictly speaking, a hypothesis derived from the therapist's model and its underlying theory.

SFBT rejects this residual of the medical model and immediately starts working toward a solution without hypothesizing a problem or its cause. SFBT starts with the assumption that clients have the resources and capacities they need (de Shazer, 1985; supported by Smock Jordan, 2013) and with the client, identifies and builds on these. The focus is on what the client wants from now on: What are the details of a life when the problem is no longer a problem? Even if the problem is irreversible, it is still possible to focus on the best possible future within that restriction. Having achieved a detailed picture of the client's preferred future, it is possible to draw out bits of this future that are happening now (i.e., exceptions to the problem; related successes). Using scaling questions, they can start to measure how far the client has already come and to articulate specific checkpoints that would indicate they are continuing in the right direction.

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Sara A. Smock Jordan, PhD, LMFT, is an associate professor at Texas Tech University in Community, Family and Addiction Services. Smock Jordan is the developer of the Solution Building Inventory, has completed outcome and process research on SFBT, and is actively involved in SFBT's growing recognition as an evidence-based practice. In addition, she is the president of the Solution-Focused Brief Therapy Association, serves on SFBTA's research

committee, and is a founding member of the organization. Smock Jordan is a Pre-Clinical Fellow of AAFMT.

Harry Korman is a Swedish psychiatrist, solution-focused therapist, trainer and supervisor, and the list administrator of the SFT-L (a solution-focused therapy listserve). With Jocelyne Korman, he founded SIKT, a solution-focused training institute in Malmö, Sweden. He teaches and lectures on SFBT internationally and is co-author of *More than Miracles*. His articles in English can be found at http://bit.ly/1kpNjcE.

Peter De Jong, PhD, MSW, is co-author (with Insoo Kim Berg) of many journal articles and the classic book, *Interviewing for Solutions*. He is an emeritus professor of social work, has been an outpatient therapist and case worker, and has trained practitioners working in mental health, family services, juvenile corrections, and school settings. He currently works as a therapist, trains, consults, and conducts micro-analytic research on therapy conversations with several colleagues.

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at the conference!

Session 202: Is Solution Focused Brief Therapy Really Different? Brief Family Therapy Center Claims and Microanalysis Results

Sara Smock Jordan
& Peter De Jong
10/17, 8:30 a.m.