Insoo Kim Berg in London

Interviewing a 65-year-old woman who says she has been seriously depressed for more than 40 years.

"So, how do you cope?"

"I don't cope … it's hell!"

"So … how do you get through hell?"

"I try to rustle up the energy to make a cup of tea."

"And that helps?"

"Sometimes."

"And when it doesn't … how do you get through hell?"

"Well … I sit there and *think* about making a cup of tea."

Not highlighting "positives" but the gentle and painstaking exploration of when this woman experiences herself as having agency — as being able to do something to influence her own situation.

FUTURE-FOCUSED INTERVIEW

Exercise in pairs.

1. Think of a change you would like to make in your life (personal life, work life ...) — don't tell me what it is.

2. Now, think of something that would be a very, very small sign to you that you had begun to make that change ... the first, smallest step (don't tell me what it is).

3. Now, let's imagine you do that very small, first thing ... how will that make a difference?

4. How will THAT make a difference?

PREFERRED FUTURE

The idea that we had been having at BRIEF was that [the term] 'goals' did not adequately reflect the breadth of description following the 'miracle question'. We began to think of it as the client describing the future they would prefer to have rather than the future they seemed to be heading towards. It was then a short step to moving from 'exceptions to the problem' to times the preferred future is already happening (or, as the Milwaukee group began to say, "Times when the miracle is happening"). We must have met you around that time and found you to be thinking along the same lines.

– Chris Iveson, London

"What if they give an unrealistic answer to the miracle question?"

"What if they give an unrealistic answer to the miracle question?" — 1. If we're careful how we ask the question, it rarely happens!

1. We first situate the miracle within the context of the client's ordinary, everyday life. "So … let's imagine … we finish talking here, and you do what you would normally do … you have something to eat, play on the computer for a while, maybe watch TV, annoy your sister a bit, maybe text a mate … and eventually, you go to bed …". This seems to be important. If we situate the miracle in the context of ordinary activities, then the miracle itself is less likely to be out of the ordinary!

2. de Shazer comments how important the way we phrase the question is. We probably say, "… and, while you are asleep, a miracle happens". He reminds how important it is to follow this with:

> **and, the problem that brought you here is solved, just like that!** … . [Pause. Now the focus is on one particular miracle that is in line with his or her coming to see a therapist. Failure to include this focal point will often lead to the client giving a response that is vague, general, and so nonspecific as to be almost useless.] (de Shazer, 1997, p. 376)

While we do not want to define the miracle for the client, we do quite deliberately place it in a particular context; that is, the context of this therapy conversation. The miracle is always placed in the context of "the reason we are having this conversation".

… while you are asleep, a miracle happens … and the miracle is that the problems you came here to therapy about are solved …

… while you are asleep, a miracle happens … and the miracle is that the things your mother was concerned about are solved …

… while you are asleep, a miracle happens … and the miracle is that the things your doctor was worried about are solved …

… while you are asleep, a miracle happens … and the miracle is that the problems that led to DCJ being involved are solved …

… while you are asleep, a miracle happens … and the miracle is that the problems your doctor thought you needed to talk about are solved …

… while you are asleep, a miracle happens … and the miracle is that the problems the school thinks you've got are solved …

We always want to place the miracle in the context of "the reason we are having this conversation".

3. Similarly, we ask, "How will you know the miracle has happened?" or "What will be different that will tell you the miracle has happened?". We do NOT ask, "What will the miracle be?"

"What if they give an unrealistic answer to the miracle question?" — 2. Just wait.

Often, clients are essentially pragmatic. They may offer an "unrealistic" answer to miracle question; however, if you don't panic and simply WAIT, often they will spontaneously redefine their miracle.

"What if they give an unrealistic answer to the miracle question?" — 3. Take a deep breath … and just go with it.

We are exploring the effects of the miracle rather than the miracle itself, so it does not matter if the initial miracle that the client proposes appears unrealistic. "She would be normal" may well be unrealistic and (in this situation) physically and medically impossible. Nonetheless, as we question further about "how will that make a difference?", clients will often begin to describe much more ordinary differences.

The more detail we get of all the things that will be different "the day after the miracle", the more likely it is that a number of these things have happened or are possible. Then, we can go on and ask, "When was the last time any of these happened?" and so on.

"What if they give an unrealistic answer to the miracle question?"— 4. Limit the scope of the miracle a bit.

Johnson and Webster (2002), writing about the use of Solution-Focused Brief Therapy with people facing chronic or terminal illness, discuss being flexible and adapting the miracle question a little.

> "Suppose a miracle happened overnight and while you were asleep you were endowed with the skills make this (problem) better, ultimately resulting in a better quality of life for you. What do you think you would notice the next day and in the following days that would give you the idea that this miracle had actually happened?"
>
> "Suppose a miracle happened overnight and you gained the ability to move beyond the problem that brought you here today."
>
> "…and you had enough energy to do things that matter to you."
>
> "…and you gained more hope." (Johnson & Webster, 2002, p. 127)

"What if they give an unrealistic answer to the miracle question?" — 5. Use the answer to "How will you know coming here has been useful?" as a platform for defining the miracle.

Interviewing a man confined to a wheelchair and who is in despair about his life, de Shazer asks, "How will you know that coming here was useful?". Simon replies, "Well, maybe I'd want to come back". de Shazer follows, "And what would tell you that maybe you wanted to come back?" and Simon replies, "Feeling better about myself". Later in the interview, de Shazer asks the miracle question and says, "and while you are asleep, a miracle happens, and the miracle is that you're feeling good about yourself, as good about yourself as you possibly can".

In the example of the woman who had recently lost her baby — "How will you know that coming and talking to me has been useful for you?" Sarah replies, "I just want my life back!" and they embark on a gentle discussion of, "So, what will be happening when you have your life back?" Early in the second meeting, the therapist asks the Miracle Question. " … and while you are asleep, a miracle happens … and this miracle is that, all of a sudden, you have your life back. When you wake up the next morning, how will you discover this miracle has happened? What will be different that will tell you this miracle has happened?"

de Shazer, S. (1997). Commentary: Radical Acceptance. *Families, Systems & Health, 15*, 375-378.

Johnson, C., & Webster, D. (2002). *Recrafting a Life: Solutions for chronic pain and Illness*. New York: Brunner-Routledge.

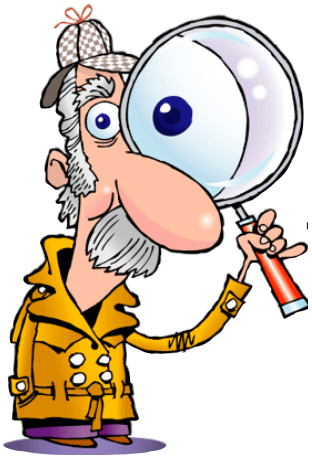
Solution-focused Scale for Alcohol Use

Name: …….. Date: ……

Please answer all questions. For each statement, indicate the degree to which it applies to you.

		Seldom	Sometimes	Pretty much	Very much
I.	**Skill Level**				
	1. I eat while I am drinking				
	2. I have no more than 4 drinks per occasion				
	3. I have no more than 20 drinks per week				
	4. I monitor my drinking				
	5. I measure each drink				
	6. I space my drinks				
	7. I dilute my drinks				
	8. I sip my drinks slowly				
II.	**Internal controls**				
	1. I handle social pressure to drink				
	2. I drink without physical problems				
	3. I feel comfortable discussing drinking				
	4. I sometimes overcome the urge to drink				
	5. I analyse my "slip ups"				
	6. I can stop after 1 or 2 drinks				
III.	**External controls**				
	1. I drink with other people				
	2. I have friends who do not drink				
	3. My spouse./family support my goal				
	4. I exercise regularly				
	5. I engage in social activities sober				
	6. I plan for drinking occasions				
IV.	**Coping statements**				
	1. I feel great in the morning				
	2. It is easy for me to relax				
	3. I sleep well at night				
	4. I can enjoy myself while sober				
	5. My spouse/family is proud of me				
	6. I take life one day at a time				
V.	**Self esteem**				
	1. I feel I am a likeable person				
	2. My friends think highly of me				
	3. Other people like to talk to me				
	4. I feel I am a good person				
	5. I have a good sense of humour				
	6. I feel proud not drinking				
	7. I feel confident about myself				
	8. People have a good time with me				

(From Brett Brasher. Based on Dolan, 1991.)



OUTCOMES RESEARCH - DOES SFBT WORK ?

There has been an increasing amount of published research suggesting that SFBT is effective.

EFFECTIVENESS (FOLLOW-UP) STUDIES

Initial outcome research involves studies where clients are followed up at some interval after the end of therapy and asked whether the problem they attended therapy about has resolved (typically on a five-point scale). "Success" is generally defined as the problem completely or significantly resolved (this is standard practice in psychotherapy outcome research, not just in Solution-Focused). These are not controlled research studies but more like "client satisfaction" surveys.

Details of a sample of these studies.

Author	*Clients*	*Follow-up period*	*Outcome*	*Av no sessions*	*Notes*
Beyebach et al, 1996	39 outpatients mental health clinic	?	80% goal achieved	5 sessions	Concrete goals and pretreatment change important.
Beyebach et al, 1999	83 clients university family therapy center	1 yr+	82% satisfied	4.7 sessions	no difference trainee / expert therapist
Burr, 1993	34 cases	9 months	77% improved	4 sessions	
DeJong & Hopwood, 1996	141 (of 275) cases	8 months	45% goal achieved (32% sig progress)	2.9 sessions	Problem type or diagnosis NOT significant
De Shazer, 1991	29 cases	1 yr	80% resolved or significant progress	4.6 sessions	Success rate increased to 86% at 18 month follow-up
George et al, 1990	62 cases	6 month	66% satisfied		
Isebaert & Vuysse,	132 alcoholics	4 year	76% stable (achieved abstinence or successful controlled drinking, according to goal)	Inpatient SFBT	Only relevant variable was therapy; social class was not a factor.
MacDonald, 1994	41 adult psychiatric cases	1 year	70% improved	3.71 sessions	longstanding problems did less well. Equal outcome for all social classes
MacDonald, 1997	36 adult psychiatric cases	1 year	64% improved	3.3 sessions	

EFFICACY (CONTROLLED) STUDIES

Effectiveness (follow-up) studies are criticised because they do not use control groups, do not control other variables and do not use "objective" measures. Thus, they may show that people, on average, improved, but they do not allow us to draw any real inferences that the particular therapy was responsible for that improvement. Academic psychology relies upon efficacy studies, which are studies subject to

proper experimental controls. If the only independent variable is the therapeutic intervention, then we can safely infer that it is responsible for any measured difference between experimental and control groups.

NOTE, however, Fishman (2000) argues that the context in which therapy occurs is so very much more complex than can be captured in laboratory efficacy studies and that effectiveness studies have higher external validity.

Gingerich & Eisengart (2000) located 18 controlled outcome studies of SFBT reported in the literature up to Summer 1999. They conclude that

- 17 of 18 studies reported client improvement; it was statistically significant in 10 studies
- 7 of the 11 studies that compared SFBT to a standard treatment reported SFBT having better or comparable outcome.

Here is a sample of the controlled studies.

Author	*Sample*	*Design*	*Results*
Cockburn et al, 1997	48 adults suffering orthopaedic injury randomly assigned	6 sessions SFBT plus rehab vs rehab only	68% SFBT at work within 7 days at follow-up vs 4% controls; also sig difference on psychometric measures.
Lambert et al, 1998	22 SFBT clients compared with 45 university mental health center clients	SFBT vs other	both groups showed same success rate on objective measure; SFBT achieved this in 3 sessions, control in 26 sessions.
LaFountain & Garner, 1996	311 school students	8 sessions SFBT groups vs "standard counseling group"	SFBT students scored sig higher on 3 of 8 psychometric scales; counselors in SFBT groups less burned out.
Lindforss & Magnussen, 1997	59 adult prisoners nearing end of sentence randomly assigned	1-12 (av 5) sessions SFBT vs standard preparation for release	12 months – 53% SFBT subjects reoffended vs vs. 76% control subjects 16 months – 60% SFBT subjects reoffended vs vs. 86% control subjects 2.7 million Swedish kroner saved by reduced reoffending.
Triantafillou, 1997	Adolescents in residential care, randomly allocated	Youth workers given SF Supervision vs given "traditional" supervision	66% decrease in "critical incidents" in SFBT group over 4 months vs 10% decrease in control group.
Seagram, 1997	40 adolescent delinquents in secure facility, in matched groups (85% history of violence, 90% repeat offenders)	10 sessions SFBT vs standard institutional care	6 months – 20% SFBT group reoffended vs. 42% control. SFBT group sig. Lower drug use, higher empathy, greater prob. solving, higher optimism.
Bozeman, 1999	52 adults diagnosed depression, randomly allocated	3 sessions SFBT vs "standard treatment"	SFBT subjects improved significantly more on Hope Scale; no sig diff on Depression Inventory.
Zimmerman et al, 1997	36 couples reporting relationship difficulties	6 weekly SFBT couple sessions vs non-clinical population	Experimental clients improved on Dyadic Adjustment Scale. At post-test, groups comparable on Marital Status Inventory.

Gingerich & Peterson (2012) report on 43 studies on SFBT efficacy and found that 74% reported significant positive benefit from SFBT.

The SFBT Research Review — http://solutionsdoc.co.uk/sft.html — lists 152 relevant outcome studies, including two meta analyses.