Solution-Focused Counseling and Motivational Interviewing: A Consideration of Confluence

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Solution-focused counseling (SFC) and motivational interviewing (MI) have gained recognition over the past 2 decades. A review of the features of these counseling approaches is provided, as well as an examination of the similarities and differences on several dimensions of counseling. Attention is given to empirical research, and it is proposed that SFC and MI be considered concurrently, which appears consistent with calls in the literature for theoretical integration. A case study is included.

Over the past two decades, two counseling styles, solution-focused counseling (SFC) and motivational interviewing (MI), have gained recognition and increased in popularity. The appeal of these styles is that they offer a respectful approach to counseling and regard the cultivation and utilization of client resources (i.e., strengths, abilities, intrinsic motivation) as the keys to positive change. The tenets of SFC and MI are primarily rooted in person-centered counseling and might be considered reactions to, or the antitheses of, problem-focused types of therapy. They represent, therefore, paradigmatic shifts in how clients are conceptualized, the counseling process, the counselor's role, and client participation in counseling.

Although MI and SFC have emerged from different origins, they share many similarities. The focus of this article is to examine perspectives shared by SFC and MI, as well as to note what we consider to be some key differences. In keeping with Polansky's (1986) call for parsimony in theoretical formulations, and following the example of recent contributors to this journal who have each compared two related therapeutic approaches (viz., responsive therapy and motivational interviewing; Gerber & Basham, 1999; Adlerian therapy and solution-focused brief therapy; Watts & Pietrzak, 2000), we suggest a counseling posture wherein SFC and MI are appropriately intertwined and intentionally practiced in coexistence. Such confluence appears appropriate and consistent with numerous recommendations for theoretical integration (e.g., Norcross & Goldfried, 1992; Prochaska & Norcross, 1999).

UNIQUE FEATURES

SFC

SFC is an evolving counseling approach conceived and developed by de Shazer and colleagues (de Shazer, 1985, 1988, 1991; de Shazer et al., 1986; Molnar & de Shazer, 1987; Walter & Peller, 1992) in the early 1980s at the Brief Family Therapy Center (BFTC) in Milwaukee, Wisconsin. It is often referred to as *solution-focused brief therapy* (i.e., a form of brief or short-term psychotherapy) in light of its emergence from the brief strategic therapy movement (Watzlawick, Weakland, & Fisch, 1974).

The solution-focused approach to counseling is considered an alternative to the problem-focused approaches that have prevailed in mental health clinical practice. Although its roots are in the work of hypnotherapist Milton Erickson and family systems theory, as well as in poststructural/postmodern or constructivist ideology (de Shazer, 1991, 1994; de Shazer & Berg, 1992), solution-focused counseling began taking shape as a reaction to the problem-resolving model espoused by therapists at the Mental Research Institute (MRI) in Palo Alto, California (Shoham, Rohrbaugh, & Patterson, 1995). Its impetus, therefore, was disenchantment with what was viewed as an interest in understanding how and why problems persist. A nonpathological, salutary, strengths- or competency-based approach to helping people was more attractive and appealing, one that Prochaska and Norcross (1999) regarded as "refreshing" (p. 440).

The foundation of SFC is the counselor's confidence in the client's ability to make positive changes in his or her life by accessing and using inner resources and strengths. The client is not provided with a blanket prescription for problem resolution nor, for that matter, told by the counselor that he or she needs to change (I. K. Berg, personal communication, November 30, 1995). Rather, the client often directs the therapeutic process (Berg & Miller, 1992) by voicing his or her preferences (Walter & Peller, 2000) and by determining the goals and outcome of therapy (de Shazer, 1990). In this regard, SFC has been characterized as "client-

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determined" (Berg & Miller, 1992, p. 7). Solutions are constructed by identifying and capitalizing on nonproblem occasions or "exceptions" to the presenting problem (de Shazer, 1988), rather than exploring and dissecting the problem. The client's strengths and competencies are fostered and then funneled toward the implementation of realistic and achievable behavioral objectives.

G. Miller (2001) regarded solution-focused brief therapy as "a radically new institutional discourse because it is based on different assumptions about social reality, new practical concerns about the therapy process, and new strategies for changing clients' lives" (p. 75). Primary assumptions include the notion that solutions are constructed rather than that problems are solved (Berg, 1995; De Jong & Berg, 1998; Gingerich & Eisengart, 2000; G. Miller, 1997), implying, in part, that knowing a lot about the problem may not be necessary to formulating a solution (de Shazer, 1988). Indeed, G. Miller and de Shazer (1998) stated that problems may be "unconnected" and even "irrelevant to the change process" (p. 370). In addition, a small change in one area can lead to greater or more expansive changes in other areas (referred to as the "ripple effect"; see Berg & Miller, 1992), often made possible by identifying "problem irregularit[ies]" (S. D. Miller, 1992, p. 2), or occasions when the problem is not a problem (past or present) or times when the client has taken, or can envision taking, a break or vacation from the problem. The "miracle question" is a primary method used for capturing these exception times, wherein the client is encouraged to imagine a time in the future when the current difficulty does not exist. Finally, counselor–client cooperation is key to the practice of counseling (Berg & Miller, 1992), with the counselor assuming the role of student and the client viewed as the teacher, a "notion that challenges the prevailing idea that the therapist dispenses wisdom and brings about cures" (McGarty, 1985, p. 149). SFC, therefore, reflects a humanistic, respectful, egalitarian approach to working with clients who are encouraged to make use of available resources and are trusted to know and make decisions about what is best for them.

MI

MI is a counseling style that emanated from the addictions field as an alternative to more traditional methods of counseling intervention, which tend to use direct persuasion and confrontation (Rollnick, Butler, & Stott, 1997). It generally adopts a brief intervention format, using critical elements that serve as catalysts for motivation and change. Indeed, W. R. Miller and Sanchez (1994) identified six critical elements as the "active ingredients" (referred to as the acronym FRAMES) necessary for successful brief interventions, which provide the background for MI: providing direct *F*eedback, emphasizing the client's personal *R*esponsibility for change, offering *A*dvice, providing a *M*enu of alternative treatment options, demonstrating *E*mpathy, and reinforcing the client's hope and optimism (i.e., *S*elf-efficacy). As with SFC, MI is not considered a theory; rather, MI is more a style or philosophy of how to strengthen client motivation to change and reduce ambivalence (Walitzer, Kimberly, Derman, & Conners, 1999). Ultimately, MI counselors help clients to cultivate their intrinsic motivational capacities (Walitzer et al., 1999) and "build commitment to reach a decision to change" (W. R. Miller & Rollnick, 1991, p. x).

In MI, the process of facilitating and enhancing intrinsic motivation and reducing resistance is guided by several principles: avoiding argumentation, rolling with resistance, expressing empathy, developing discrepancies, and supporting self-efficacy. Because arguing with clients tends to evoke resistance, opposition, and defensiveness, MI practitioners avoid harsh confrontations, accusations, and labeling (W. R. Miller & Rollnick, 1991, 2002). They instead "roll with resistance" by acknowledging that reluctance to change a firmly entrenched behavior is natural and understandable (W. R. Miller & Rollnick, 1991). An essential and defining characteristic of MI is expressing empathy (W. R. Miller & Rollnick, 1991, 2002), which, according to William Miller (personal communication, December 8, 1999), ranks as one of the most important components of MI. This therapeutic milieu not only lowers resistance but also encourages client self-motivational statements (W. R. Miller & Rollnick, 1991) or client *change talk* (W. R. Miller & Rollnick, 2002), that is, client speech affirming his or her decision to change or consider change.

MI uses confrontation in the sense of creating and amplifying discrepancies between present behaviors and client values. The goal is to bring to the client's awareness discrepancies within the client by clarifying goals and values and exploring consequences of present behaviors that appear to conflict with these goals and values (W. R. Miller & Rollnick, 1991). As a client becomes aware that change is needed, MI practitioners seek to help strengthen what Bandura (1977) termed *self-efficacy*, or the client's perception of his or her ability to change and manage obstacles on the path to change. MI emphasizes that many clients become aware of the need for change; however, they may also have limited confidence and hope that they can make a successful alteration in behavior. MI counselors bolster this confidence and hope, which is a step beyond simply recognizing the need for change.

SFC-MI SIMILARITIES

Nonpathological, Salutatory Focus

Because both SFC and MI emerged in response to and in contrast with prevailing medical/disease and problem-focused models, they can be said to represent nonpathological and salutary or health-promoting therapeutic ventures. An interest in and a curiosity about client abilities, strengths, and competencies characterize both SF and MI counselors. "Excavating," "dissecting," and even "excising" client liabilities, problems, and "character defects" (as mentioned in the 12 Steps of Alcoholics Anonymous) or deficiencies are not the primary concern.

An example of MI's nonpathological vein is its avoidance and, indeed, intolerance of diagnoses or labels, regarding such

practice as dehumanizing. In contrast to traditional substance abuse treatment approaches, MI eschews "branding clients with names" (W. R. Miller, 1999, p. 11), such as "alcoholic," "addict," or "in denial." Furthermore, it is assumed that the client does want to be healthy and desires positive change, viewing such a desire as inherent (Lewis & Carlson, 2000a). Positive reframing, therefore, is encouraged so that what was once considered a deterrent to change (e.g., the compulsivity of addiction) can be considered an asset (e.g., the persistence of recovery), such as the consideration of a client's "multiple sobrieties" as opposed to his or her "multiple relapses."

Similarly, SFC maintains an emphasis on mental health (Berg & Miller, 1992), presupposing that positive change is possible and preferring a preoccupation with exceptions or nonproblem occasions. Care must be taken, however, that there not be a rush to formulate solutions or that only "solution talk" be permitted. These are characteristics of the solution-forced therapist described by Nylund and Corsiglia (1994) and echo concerns that SFC neglects problem elicitation (Kuehl, 1995) and clarification (Fraser, 1995, 1999), as well as client history and broader assessment (Stalker, Levene, & Coady, 1999), which may contribute to a tendency to adopt an either/or view of solutions (Walter & Peller, 1994). The nonpathological and salutary focus of both SFC and MI, therefore, does not (and should not) regard health as the simple opposite of disease (see Antonovsky, 1987) or imply that difficulties or problems are to be eliminated. Rather, both counseling approaches place more emphasis on what is working well for the client, rather than what is not (Berg & Miller, 1992), and help the client get back "on track" (Walter & Peller, 1994) and maintain the benefits of change, which may represent increasing the length of time between relapses and adopting a harm reduction approach (W. R. Miller, 1999).

Multiple Perspectives

With varying degrees of emphasis, MI and SFC reflect a social constructionist, postmodern influence. In contrast with modernist philosophy, which stresses the existence of a single, tangible social reality, postmodern philosophy argues the existence of multiple, intangible social realities (Gergen, 1991). As a component of the postmodern perspective, social constructionist thinking contends that the languages we use largely shape our social realities (Guterman, 1996). That is, social realities are coconstructed by the choice of words we use to communicate in conversation. The social constructionist influence is apparent in SFC, which emphasizes the coconstruction of multiple "possibilities" rather than one. Indeed, the SF practitioner strives to coconstruct with clients alternative attitudes, different ways of perceiving, and solutions to presenting concerns (Walter & Peller, 1992).

MI reveals elements of constructivistic thinking, evident in the recommendation that counselors generate with clients a "menu" of alternative interventions or options (W. R. Miller, 1999). Thus, the client is not persuaded to adopt a sole suggestion provided by the counselor, but is invited to consider several alternatives that emerged through counselor–client discussions. This precludes the possibility of the client becoming mentally fixed on one option and, instead, allows the client to consider the problem through multiple perspectives.

Anchored in Change

MI is closely aligned with the stages of change model (DiClemente & Velasquez, 2002; Prochaska, DiClemente, & Norcross, 1992). This model suggests that all clients progress through a series of identifiable stages in the counseling process: precontemplation, contemplation, determination, action, maintenance, and relapse. According to MI, a critical component in the counseling process is to match counselor interventions with whatever stage of change the client is experiencing. Counseling strategies that are stage specific reduce therapeutic resistance and simultaneously increase intrinsic motivation (W. R. Miller & Rollnick, 1991). This makes MI a particularly useful approach for "challenging clients" who present with little or no motivation to change (i.e., those who are precontemplative or contemplative about change), even though there is an assumption that clients do want to make positive change. Rather than assuming that all clients are "ready for action," MI recognizes that many clients may initially be ambivalent about changing. This counseling approach provides a perspective that facilitates movement through the change process.

SFC is also anchored in positive change, with a consistent emphasis on what the client will be doing (changing) to reach a solution and how he or she will be doing it (Walter & Peller, 1992). Change occurs through action because action is the process through which changes in thinking and behavior come about (Walter & Peller, 1992). Indeed, SFC can be thought of as "solutioning therapy" or "goaling therapy" (Walter & Peller, 1992), implying the idea that positive change is not a static event, but an action-based, process-oriented phenomenon. This appears consistent with MI's focus on the stages of change model, where change is not fixed indefinitely but evolves and progresses through client action (motivation). Similar to MI's matching of interventions with a particular stage of change, SFC assumes that change is more likely to occur when counselors cooperate to match each client's style of engagement and adjust tasks to fit the client's mode of operation (Walter & Peller, 1992). Whereas MI and SFC adopt somewhat different procedures for encouraging change in clients, both operate with a persistent focus on the capabilities clients have to evoke positive change in their lives.

Reframing "Resistance"

Traditionally, resistance has been perceived as something that lies within the client. If therapeutic progress is not made or an impasse is reached, blame is placed on the client who is said to be "lazy," "unmotivated," or "resistant." MI and SFC offer a much different perspective on resistance, how it manifests in counseling, and counselor strategies to address it. From the MI viewpoint, counselor style is a powerful determinant of resistance and change (W. R. Miller,

1999; W. R. Miller & Rollnick, 1991, 2002). Thus, resistance is greatly affected by interpersonal interactions between the client and the counselor. In other words, resistance is not viewed as something exclusively "in" the client; rather, it is a relational phenomenon that lies within the counselor–client relationship (W. R. Miller & Rollnick, 1991, 2002). Unlike traditional views of resistance, MI encourages counselors to reflect on how their interactional style may contribute to resistance in the therapeutic milieu.

From the MI perspective, the counselor's response to resistance can largely determine the client's subsequent willingness to engage in the counseling process (W. R. Miller & Rollnick, 1991). As noted previously, rather than striving to "break down" resistance, MI counselors "roll" with resistance by reflecting statements and feelings, offering new perspectives (but not imposing these on clients), and demonstrating empathy (W. R. Miller, 1999). Clients are in an auspicious position to discover their self-healing capabilities (see Bohart & Tallman, 1999) when placed in an environment that is nonjudgmental and avoids argumentation.

In a humorous look at resistance, therapists at the BFTC made a "declaration of the death of resistance" and even held a funeral to grieve its loss (O'Hanlon & Weiner-Davis, 1989, p. 21). Consistent with the MI view, SFC disputes the fundamental belief of most contemporary therapies that clients really do not want to change and that their resistances must be "attacked" (O'Hanlon & Weiner-Davis, 1989). Such approaches, according to the SFC perspective, promulgate an adversarial us-versus-them strategy that takes the focus away from solutions (O'Hanlon & Weiner-Davis, 1989).

SF counselors believe that clients do want to change, and if a client neglects to follow a counselor's suggestion, it is simply a sign that the counselor and client are not on the same page (O'Hanlon & Weiner-Davis, 1989; Walter & Peller, 1992). Rather than "breaking down" client resistance through confrontation, SF counselors seek to understand a client's idiosyncratic way of cooperation and interact with the client in a manner consistent with this. According to SFC, focusing on client resistance is a "blind alley" that counselors should avoid (O'Hanlon & Weiner-Davis, 1989). Similar to the MI perspective, SFC holds that, too often, resistance is a convenient label counselors give to clients when an impasse has been reached. Labeling clients, incongruent with both MI and SFC, precludes the development of solutions and working with the client as a partner.

Cooperation Is Key

William R. Miller (personal communication, December 8, 1999) commented that traditional U.S. treatment (especially in the addictions field) has been extremely authoritarian and described it as the "I know best, you're impaired, listen to me" mentality. From his perspective, this paternalistic emphasis directly prescribes action (usually only one action—the therapist's), promotes aggressive "confrontation of denial," and institutes moralistic blaming when changes do not occur. According to W. R. Miller, there are still plenty of programs that adopt this philosophy, despite the widespread belief that such treatment does not exist. MI avoids this emphasis on a confrontational style, promoting instead a gentle persuasive style in which cooperation is a key element for successful counseling (W. R. Miller & Rollnick, 1991, 2002).

MI stresses client personal responsibility and self-determination for change (W. R. Miller & Rollnick, 1991; Smyth, 1996) and promotes working cooperatively and democratically with the client to generate alternative solutions to behavioral problems. Several principles of MI, including avoiding argumentation, rolling with resistance, and expressing empathy, suggest that the client is not perceived as an opponent to be defeated but as an important ally who offers a critical perspective in counseling (W. R. Miller & Rollnick, 1991, 2002). This is similar to regarding the client as the "teacher" and "expert" in SFC (Berg & Miller, 1992), underscoring the commitment that both approaches have toward cooperation instead of confrontation.

In SFC, cooperation is strengthened by focusing observations on what clients are already doing to reach their goals. Because resistance is no longer in the clinician's perceptual field, a positive atmosphere is established in which the counselor and client are genuine with each other (O'Hanlon & Weiner-Davis, 1989). Disagreements are incorporated into the counseling process as a way to further promote client–counselor cooperation (Walter & Peller, 1992).

SF counselors assume that clients hold critical beliefs on how change takes place relative to their goals (Walter & Peller, 1992). Therefore, it is up to the counselor to cooperate with these views, while facilitating a process in which clients are invited to consider new possibilities, differences, and solutions (Walter & Peller, 1992). According to Walter and Peller (1992), two principles of cooperation are "pacing" and "inviting." Pacing involves matching the client's tone, affect, and words, so as to demonstrate understanding and acceptance. This is analogous to MI's emphasis on expressing empathy. Inviting involves using questions to gently ask the client to consider or explore new meanings and possibilities. Although using different vernacular, MI also makes use of inviting questions, which are designed to evoke self-motivational statements (statements affirming the client's commitment to change; W. R. Miller, 1999). Cooperation, from the perspectives of MI and SFC, allows clients to feel supported, which facilitates openness toward future possibilities and new directions.

Use of Client Strengths and Resources

MI and SFC use client strengths and resources in ways to promote positive change. MI promotes self-efficacy by conveying the message "you have the ability" and "you can change." This is similar to the SF counselor's role in giving positive feedback in the form of statements of encouragement, compliments, and affirmations (Walter & Peller, 1992). MI counselors may also bolster self-efficacy by discussing previous client success stories, strategies that have been suc-

cessful for the client in the past, and client strengths in general, strategies that are also used in SFC.

As noted earlier, both MI and SFC stress that the responsibility for change lies with the client, not the counselor; both approaches will not allow clients to place the onus of change on the counselor. Implicit is that clients have within themselves the capacity to consider new or different meanings, coconstruct solution-focused realities, and generate sufficient intrinsic motivation to change.

Temporal Sensitivity

Both SFC and MI can be considered time-sensitive approaches, with their respective ties to brief therapy and to brief interventions in the area of addictions counseling. Temporal sensitivity implies that time is valued and respected in counseling because it is not unlimited and counselors make the best use of their time with clients, working efficiently and judiciously. The approach to counseling that both SF and MI practitioners take can be likened to that of theologian Henri Nouwen's therapist who, according to Nouwen (1976) "gave me much time and attention but did not allow me to waste a minute" (p. 15). In this manner, SF and MI counselors can be said to use time wisely, keeping themselves and their clients focused, without the impression of being rushed.

Whereas SFC is not regarded today as an exclusively short-term or time-limited approach, MI is. Hoyt (1990), who has written extensively on brief therapies and SFC, views time not so much as a commodity but more as a perspective. In this way, SFC can be used in not-so-brief formats, such as with recovering, alcohol-dependent, single-parent mothers (Juhnke & Coker, 1997) and persons with thought disorders (Hagen & Mitchell, 2001). MI, on the other hand, "was designed from the outset to be a brief intervention and is normally delivered in two to four outpatient sessions" (W. R. Miller, 1999, p. 55). Extensive research on brief interventions and MI (often one and the same) regard the temporal limitation of therapeutic activity as the operative variable.

SFC–MI DIFFERENCES

Social Construction Through Language

Both SFC and MI speak to the importance of therapeutic collaboration and the intentional use of nonjudgmental, respectful, and engaging language with clients. These exemplify humanistic counseling practices. SFC, however, emanates from and is shaped by poststructuralist, postmodern, or constructivistic/social constructionistic thought, which not only regards the consideration of multiple perspectives but also views the construction of reality as the product of human interaction through language. In this sense, the act of counseling is a process of "languaging" (Maturana & Varela, as cited in Walter & Peller, 2000), wherein counselors resemble "linguistic detectives" (Efran & Cook, 2000, p. 140) and practice as "conversational facilitators of clients' solution-building" (G. Miller, 2001, p. 75) and "curious conversationalists" (G. Miller, 2001, p. 80). Indeed, de Shazer and Berg (1992) have proposed that language *is* reality.

It is evident in our observation of several SF practitioners (e.g., Insoo Kim Berg, Scott D. Miller, and Linda Metcalf) that effort is made not only to adopt the language of their clients but also to mutually consider and experiment with new ways of thinking and talking about the client's experiences and aspirations. No assumptions are made about what would be best or even most helpful for the client. Rather, the SF counselor assumes a "not-knowing" stance (Anderson & Goolishian, 1991), using questions to "wonder out loud" with the client about what might be helpful. Solutions take their shape, therefore, in the moment, during the client–counselor exchange, wherein both are considering, pondering, experimenting with, formulating, and contributing to a possible scenario or reality that the client can identify with and views as helpful. Indeed, "solutions emerge from dialogues" (Prochaska & Norcross, 1999, p. 444). A goal of counseling may simply be to help the client begin shifting his or her language from talking about problems to talking about solutions (Nichols & Schwartz, 2001). In this manner, SFC exemplifies Anderson's (1997) conceptualization of therapy: "a language system and a linguistic event in which people are engaged in a collaborative relationship and conversation—a mutual endeavor toward possibility" (p. 2).

Although MI mentions the importance of using language that does not convey judgment (e.g., client who is "in denial" or "resistant"), and presents strategies that involve the counselor's use of inflection and positioning of words (e.g., "double-sided reflection" and "agreement with a twist"), the client–counselor verbal exchange is not necessarily viewed (as is SFC) as a new reality "under construction." In this way, MI may exemplify a phenomenological approach (i.e., counselor attempts to view life from the client's perspective and identify goals from that vantage point) more so than SFC (which seeks to formulate a new reality, a new perspective, mutually constructed by the client and counselor). This is evident in the prominent use of reflective statements in MI, whereas SFC makes use of a variety of questions (e.g., exception, coping, scaling questions) intended to generate possible solutions and convey that counseling is a collaborative venture, an exercise in "mutual puzzling" (see Anderson & Goolishian, 1991).

Concept of Change

MI uses a well-defined model of change—the stages of change model (DiClemente & Velasquez, 2002; Prochaska, 1999), which proposes that individuals pass through stages in the course of solving a problem. This model of change aids MI counselors in conceptualizing the level of client motivation and implementing stage-appropriate motivational interventions. Enhancing commitment to change requires MI counselors to be sensitive to levels of ambivalence and resistance, which manifest differently depending on what stage of change a client is presenting. From the MI perspective, change is a process that occurs as clients resolve ambivalence while moving

through the stages of change (i.e., from precontemplation to maintenance), and simultaneously cultivating greater levels of intrinsic motivation to alter behavior.

Recall that SFC assumes that resistance does not exist and that clients genuinely want something from counseling and do want to change (Walter & Peller, 1992). As such, SFC does not follow a clearly defined model of change or concentrate on a client's progression through systematic stages of change. It does, however, offer strategies that facilitate new possibilities and changes in perspective (G. Miller, 1997). For example, the use of "scaling questions" and the "miracle question" serve to encourage clients to imagine what change and success might look like in the future. Scaling questions imply movement or change along a linear continuum, as when a counselor asks a client what changes would occur if he or she were at a "7" as opposed to a "5" (say, on a scale where "10" was considered "all the confidence in the world" and "0" was presented as "no confidence at all"). Scaling questions are often used as assessments of presession change (Lawson, 1994). If clients indicate movement in a positive direction on the scale, counselors inquire as to how the client was able to make changes and encourage him or her to do more of what is working. Clients who are asked the miracle question are encouraged to clarify concrete changes imagined after the miracle has taken place.

Counselor Focus and Goals

Both SFC and MI view positive client change as possible. Methods adopted for realizing such change, however, differ. To begin with, MI emphasizes the importance of assessment, particularly attending to the stage of change a client is manifesting and his or her readiness for change, apparent discrepancies, and the level of resistance in the counseling session. Although scaling questions and inquiries about "pretreatment change" (Beyebach, Morejon, Palenzuela, & Rodriguez-Arias, 1996; Lawson, 1994; Weiner-Davis, de Shazer, & Gingerich, 1987) used in SFC can be said to be a form of assessment, it is not the difficulty or complaint that is being evaluated (a practice criticized by some; Fraser, 1995, 1999; Kuehl, 1995; Stalker et al., 1999); rather, the focus is on identifying possible exceptions (i.e., instances in which the client has successfully dealt with a problem) so the client can generate solutions. Furthermore, a primary focus and strategy in MI is to identify and amplify client discrepancies (e.g., between current and ideal behavior, or between values and current behavior) in an effort to fuel client's commitment to initiating change. In contrast, what is identified and amplified in SFC are exceptions to the problem so that the client can do more of "what's working."

To address resistance, MI is confrontational in the sense that it adopts a gentle, strategic, and persuasive style designed to increase a client's awareness of a need for change (W. R. Miller & Rollnick, 1991, 2002). This characterizes the directive approach of MI, which can also include advice giving (or idea offering) with certain guidelines. Once a client becomes sufficiently motivated to change, MI's focus shifts to strengthening the client's commitment to changing behavior (W. R. Miller & Rollnick, 1991, 2002). These foci and strategies assist MI practitioners in accomplishing their ultimate goal: facilitating a client's intrinsic motivation to consider and implement changes in behavior.

SFC counselors emphasize honoring the client's preferences for change (Walter & Peller, 2000), which implies that clients are capable of doing what they need to do to get what they want (Walter & Peller, 1992). This is slightly different from a focus on enhancing intrinsic motivation. In SFC, attention is focused on coconstructing goals and solutions (G. Miller, 1997), directed by client preferences (client as expert), with the counselor maintaining an "eye for exceptions."

Temporal Focus

MI is primarily a present-focused style of counseling, evident in the prominent use of reflective statements. This is not to say that MI practitioners eschew any discussion of future actions; however, the thrust of MI is addressing the client's current stage of change and facilitating the enhancement of intrinsic motivation in the here-and-now. SFC, on the other hand, tends to be present- and future-oriented. The emphasis on the future materializes through the previously discussed scaling, miracle, and hypothetical questions, which encourage the client to think about what a solution might look like in the future and what he or she will be doing differently when the problem is solved.

Reflectivity

We have already mentioned SFC's exemplification of postmodern or social constructionistic thought, which has as its premise the consideration and creation of multiple realities (because there is no one absolute reality) through the process of "languaging." Inherent in this philosophy is the need for active reflection, wherein individuals take time to intentionally consider or ponder the meaning or implications of a particular experience, event, or course of action from a variety of perspectives. Because realities are always "under construction," careful and disciplined reflection guides the formation of a new reality or perspective and, indeed, allows them to take shape.

SFC makes intentional use of reflection, viewing the therapeutic exchange as a disciplined exercise in mutual reflection, without a predetermined goal, destination, or end result in mind. In this manner, it is not only the counselor who engages in reflection; he or she models and encourages the client to do so also. This reflective activity takes place in the moment, during the counseling session itself, not only outside of the session (e.g., when the client may be encouraged to journal). The SF counselor demonstrates a reflective approach when he or she assumes a "not-knowing" position, poses questions to the client about possible variations of the current perspective or experience, and "wonders aloud" with the client about relevant and feasible solutions. In addition, many SF counselors have adopted the routine of taking a break near the end of a session to consult with a colleague or to gather his or her own thoughts privately in order to "pack-

age" and then provide helpful feedback and recommendations to the client at the close of the session (Lewis & Carlson, 2000b). Creating this physical distance and space promotes careful reflection.

MI might also be thought of as an exercise in reflection, firmly based on and influenced by a person-centered or Rogerian theoretical perspective. It appears, however, that such activity is primarily the responsibility of, and is carried out by, the MI counselor through the use of empathic, reflective statements. Cultivating client–counselor mutual and deliberate reflection does not appear to be a goal or the purpose of MI, as it is in SFC. Rather, because MI is goal oriented, MI counselors assume an intentionally directive approach (W. R. Miller & Rollnick, 2002), encouraging movement toward an outcome amenable to the client. Reflection in MI, therefore, (a) is intended to communicate counselor empathy; (b) promotes client–counselor collaboration and hence, reduces resistance; and (c) allows the counselor to formulate a strategy toward change that is acceptable and attractive to the client.

RESEARCH FINDINGS AND DIRECTIONS

Research on SFC

SFC has been criticized for its lack of an empirical research base (Eckert, 1993; Fish, 1995, 1997; S. D. Miller, 1994; Shoham et al., 1995; Stalker et al., 1999) despite its more than 20 years of practice. Most of the studies reporting the effectiveness of SFC have been promulgated by its founders, clinicians at the BFTC in Milwaukee, Wisconsin, and students of the BFTC training center. These reports are "substantiated solely by reference to 'subjective clinical experience'" (S. D. Miller, 1994, p. 21) and are often presented in anecdotal form.

Two studies reporting favorable outcomes (viz., length of treatment, and achievement and maintenance of client goals) of solution-focused brief therapy (SFBT) have frequently been cited in the SFBT literature (see Kiser & Nunnally, 1990). These studies, however, were conducted at the BFTC by Center staff, were based on "poorly designed" methodology, and have not been published (D. Kiser, personal communication, January 11, 1996). Claims of its utility and efficacy, therefore, are purely theoretical and have not been subjected to sound empirical testing (Fish, 1997; Shoham et al., 1995).

Although existing outcome research is less than adequate and must be interpreted cautiously (Fish, 1997; McKeel, 1996), Gingerich and Eisengart (2000) reviewed 15 outcome studies of SFBT, five of which were determined to have met established standards for empirically supported psychological treatments. Two of these studies reported significant outcomes favoring a solution-focused approach: return to work for patients with orthopedic injuries, in comparison to a standard rehab program (Cockburn, Thomas, & Cockburn, 1997); and less recidivism for prisoners involved in an SFBT treatment group, compared with a control group, up to 16 months after release (Lindforss & Magnusson, 1997). Efforts are underway, therefore, to demonstrate efficacious outcomes of a solution-focused approach, addressing what has been acknowledged as a "shortcoming" of SFC (Lewis & Carlson, 2000b). These efforts, however, do not compare with, and trail far behind, the consistent rigorous investigations of the effects of a MI approach.

Research on MI

MI has a larger empirical research base than SFC and, of the research conducted by both counseling approaches, MI has incorporated more methodologically sound investigations that purport its clinical effectiveness. The strength of many of these investigations involves the use of randomized controlled trials (of which a few are mentioned as follows; see Burke, Arkowitz, & Dunn, 2002, for a review of 26 controlled clinical trials using MI), which serve to bolster internal validity and control for extraneous factors that can compromise findings.

In a study that compared MI principles and methods with a confrontational counseling approach among problem drinkers, W. R. Miller, Benefield, and Tonigan (1993) found that therapist behaviors associated with the term *confrontational* were found to predict poorer outcomes for problem drinkers. Successful therapeutic styles were those that evoked positive motivational responses from clients without engendering resistance. Bien, Miller, and Boroughs (1993) found similar findings in a study comparing motivational interviewing with a control condition among 32 individuals experiencing alcohol problems. Participants who engaged in the MI treatment condition reported consuming fewer standard drinks, lower peak blood alcohol levels (BALs), and a higher percentage of days abstinent than did control participants at 3-month follow-up. Similar findings supporting the effectiveness of brief motivational interventions were reported by W. R. Miller (1996).

Rollnick et al. (1997) outlined a program to help smokers make decisions regarding their health status and behavior. This three-phase intervention implemented several MI elements such as brainstorming solutions (offering menu), bringing out discrepancies between what the client likes and dislikes about his or her current behavior, and questions to assess self-efficacy. In a qualitative examination of this program, these researchers reported satisfaction from both clinician and client perspectives. For example, several clinicians stated that the emphases on client responsibility, rapport building, and active client decision making were admirable components. Clients seemed to believe they were doing something positive for themselves, instead of being the recipient of a lecture.

More recently, Borsari and Carey (2000) conducted a randomized controlled trial comparing a one-session motivational intervention with a no-treatment control among binge-drinking college students. Although the length of follow-up was relatively short (6 weeks), Borsari and Carey found that students who engaged in the MI treatment condition consumed fewer drinks per week and had fewer binge drinking episodes in the month after treatment.

The efficaciousness of MI has been examined among participants with more severe addiction problems. For example, Stotts, Schmitz, Rhoades, and Grabowski (2001) evaluated brief MI within the context of an outpatient cocaine-detoxification program. One hundred and five participants were randomly assigned to MI treatment or a detoxification-only condition. Results suggested that MI participants had fewer positive urine samples and were more likely to increase their behavioral coping repertoires compared with the detoxification-only participants.

The application and effectiveness of MI has been established in other areas besides substance-related issues. For example, W. R. Miller (1996) reported that MI strategies have been applied successfully to HIV–risk behavior, sexual offenses, diabetes, pain management, and cardiovascular rehabilitation. Bellack and DiClemente (1999) proposed a comprehensive treatment for patients with schizophrenia and substance abuse, focusing on MI to assist clients in goal setting and reducing the use of substances. An investigation by W. R. Miller, Meyers, and Tonigan (1999) provided support for a counseling program designed to help concerned significant others encourage their loved ones to enter treatment. The authors commented that this program, based on the principles of MI, "is substantially more effective than the two more commonly practiced approaches in engaging initially unmotivated problem drinkers in treatment" (p. 695).

STYLE INTEGRATION

Considerations of commonalities and the coexistence of therapies are to be expected with more than 400 models of psychotherapy now available (Corsini & Wedding, 2000; Prochaska & Norcross, 1999). Chief among these is the expanse of literature on what is referred to as "theoretical integration" (Norcross & Goldfried, 1992; Prochaska & Norcross, 1999), based on and driven by the notion of common factors (Lambert, 1992). From this perspective, factors *across* therapies contributing to positive outcomes are emphasized, rather than attempts at isolating the unique contributions of a *particular* therapeutic approach. Additional examples of an integrative milieu in psychotherapy and counseling today include W. R. Miller and Hester's (1995) informed eclecticism in the addictions and Gergen's (2000) reference to creative confluence wherein schools of therapy are connected by the significance of human meaning.

With both SFC and MI advocating for the consideration of multiple perspectives, with SFC being promoted as adaptable to (or compatible with) other approaches (Guterman, 1996), and furthermore, with MI itself informed and guided by a transtheoretical theory of counseling and psychotherapy (see Prochaska, 1999), a consideration of the coexistence and confluence of both counseling styles appears appropriate and consistent with themes inherent in both approaches. What follows represents our preliminary attempt to understand and articulate SFC and MI from an integrative and a both/and perspective in the hope of promoting the strengths of a synergistic emergence. This is followed by a case study demonstrating the possible application of an integrative perspective.

Honoring Client Stories

What is paramount to us in the confluence of SFC and MI is a respectful and humanistic therapeutic posture that values and, indeed, honors (even relishes in) the unique stories and experiences of clients. Counselors remain curious about and intrigued by the client's idiosyncratic perspectives and preferences. Although the tributaries of such a respectful stance originate from different sources (SFC from a constructivistic/social constructionistic philosophy, and MI from Rogerian therapy), the resulting integration reflects a cohesive and adamant appreciation for and use of client constructions and presentations. That is, clients are regarded as the experts about or the authorities on their experiences. This means that the counselor invites and welcomes the client's unique contributions to therapeutic interactions and conversations and adjusts to the client's proclivities. SF and MI counselors are therefore the students of their clients' preferences, adjusting their stance to "fit" with or accommodate and adapt to the client's needs.

Motivation as a Client Resource

Client motivation in MI can be likened to client preference in SFC. Both refer to client resources and strengths that are identified and amplified in the course of therapeutic encounters. What is critical is that the client's intrinsic intentions and preferences are recognized (e.g., client's image of being reunited with his or her children, client's eagerness to fulfill the requirement of counseling) and incorporated into counseling interactions and tasks. This includes the client's ambivalence about change, for this taps into the client's source of energy or energy reserves (e.g., client mental and emotional investment in the consideration of several possibilities, which may have resulted in a feeling of "stuckness") and makes room for the possibility of client engagement and cooperation.

Such recognition and arousal of intrinsic motivation in constituents is regarded as a necessary characteristic of effective leaders (Kouzes & Posner, 1995). Kouzes and Posner stated that "Reliance upon external incentives and pressures doesn't liberate people to perform their best, and it constrains leaders from ever learning why people *want* to excel" (p. 41). Identifying and appreciating what propels the client to either filibuster or consider change opens the door for more collaborative dialogue and encourages client aspirations of something different and rewarding.

Change in Relation

The process of identifying and cultivating client intrinsic motivation or preferences takes place within a relationship, and it is in this therapeutic relational and conversational process that change occurs or emerges. Indeed, both SFC and MI exemplify one of the prominent common factors—

the therapeutic relationship—credited with being responsible for approximately 30% of positive client change (Lambert, 1992).

From an integrated SFC and MI perspective, however, change is not something that happens only to the client or that is limited to the client. That is, movement in counseling is not confined to client performance or status, as if the client directs or is solely responsible for such movement and change. Rather, when considered in the light of SFC and MI confluence, change is understood in terms of conversational or relational movements or fluctuations over time, illustrating the systemic, holistic, dynamic or interactional, and recursive nature of counseling and the counseling process. Indeed, SFC speaks of three types of client–therapist relationships (customer, complainant, and visitor; Berg & Miller, 1992) and not three types of clients. Although MI refers to stages of change based on client presentations, it is understood that change is an interactive phenomenon, reflecting both client and counselor contributions, and recent discussions (e.g., Prochaska, 2000) have focused on the therapeutic relationship at each stage. The integration of SFC and MI, therefore, suggests a reconceptualization of therapeutic change as relational and communal (i.e., the relationship as not only the agent of change, but also the subject of change).

Case Study: Integration in Action

I (first author) had a unique opportunity to work in a community counseling agency that strongly endorses SFC and MI. Although a confluence of SFC and MI was not emphasized throughout the agency, I was encouraged in supervision to apply the combined strengths of SFC and MI.

Mark D. was a 39-year-old White man, employed as an auto mechanic at a local auto shop. Mark had been court-ordered to attend counseling due to a third driving-under-the-influence (DUI) offense. Two 50-minute sessions were devoted to assessing the extent of Mark's substance use, attitudes toward use, and associated consequences. Mark's assessment results indicated possible alcohol dependence, and, while providing him feedback from the assessment, I noted a moderate to strong amount of frustration. "I don't see why I have to go through all of this," Mark said. "Can't we just get on with the counseling and be done?" I concluded that Mark appeared to be in the precontemplative stage regarding his drinking behaviors.

Throughout Mark's counseling, I maintained a posture of curiosity and intrigue and established rapport by listening empathically to Mark's "story." Honoring Mark's perspective and showing genuine interest in his construction of reality seemed to open space for reflection and consideration of alternative ideas. Mark seemed a bit surprised when I stated, "I'm really curious to learn, from your perspective, what happened when you received your third DUI. . . . Tell me what that experience was like for you?" As the resistance between Mark and me lessened, Mark was more willing to offer his perspective on his drinking behavior, its impact on himself and others, and recent legal troubles. Believing that his story was *heard*, Mark began to acknowledge the possibility that drinking had caused a strain on his marriage, his relationship with his two children, and his job.

Building on Mark's awareness of problems related to drinking, I assisted Mark in exploring and amplifying his strengths and resources that he could draw on to accomplish counseling and personal goals. I explored previous times when Mark overcame difficult circumstances in his life (i.e., exceptions). Remembering and reliving these experiences bolstered Mark's self-efficacy as he began to develop the intrinsic drive to change his behavior. By this time, Mark had verbalized preferences for change (i.e., wanting to get along better with his spouse and children, wanting to keep his job). Because these preferences emanated from Mark's own motivation, I incorporated them as goals for counseling and helped him construct "homework" tasks designed to improve his relationships with others. It became clear that what propelled Mark was what he valued: family life and doing well in his job. Through cooperative dialogue, Mark came to view alcohol as an unnecessary roadblock to happiness.

On termination of counseling, Mark had committed to abstaining from alcohol and was willing to sign an "abstinence contract." He even considered marital counseling to assist with relational issues. It is interesting that when I asked him what was most helpful in counseling, Mark stated that my "honest, nonjudgmental approach" was most appreciated and something quite different from what he was used to in previous counseling and in the legal system. I pointed out, however, that Mark had made important contributions as well and that our combined, cooperative venture provided the foundation and impetus for growth and change. Indeed, reflecting on my interactions with Mark, I became aware that as our relationship became more *egalitarian*, *genuine*, and *cooperative*, space opened for reflections, considerations for change, and the coconstruction of creative, alternative ideas.

CONCLUDING REFLECTIONS ON CONFLUENCE

The case of Mark illustrates that using SFC and MI synergistically can be effective in building a strong therapeutic alliance and reducing initial resistance to change. The counselor (first author) illustrated this by honoring Mark's story, taking a position of curiosity, and demonstrating a genuine interest in his perspective. Amplifying Mark's strengths, illuminating previous times when he was successful in overcoming difficult circumstances, and encouraging coconstruction of goals also demonstrated confluence. SFC and MI operate under the assumption that clients can offer a critical perspective in counseling. Because he believed his ideas were respected, and because he had the supportive context of a strong counseling relationship, space was opened for Mark to examine his behavior and verbalize a preference to reduce his drinking. This is consistent with SFC, which promotes client preferences for change, and with MI, which emphasizes *the client making the argument for change* (i.e., enhancing intrinsic motivation). Highlighting the important

contributions and considerable input that Mark offered in relation to his own counseling further illustrates the "essence" of a synergistic approach. That is, SFC and MI effectively combined can encourage change through a collaborative and respectful counseling relationship, honoring client stories, and recognizing client strengths, intentions, and preferences as important components in the client's own healing.

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