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Abstract
The purpose of this paper is to provide an overview of the Solution-Focused Therapy philosophy, including some of its basic assumptions and their application in therapy. In doing so, the history of the development of Solution-Focused Therapy will be examined. Covered in this review is a summary of some of the elements borrowed from Social Constructionism and traditional therapies. The underlying assumptions of Solution-Focused Therapy to be examined include its focus on strengths, its particular view of reality (especially in regard to how expectations and the use of language affect outcome), and understanding change.

The therapist's conceptualization of the client and the therapist's role will also be examined, as well as purported limitations of Solution-Focused Therapy. Some ways of minimizing these stated limitations will also be discussed.

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SOLUTION-FOCUSED APPROACH TO THERAPY: AN OVERVIEW OF THE LITERATURE

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Presented to
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Solution-Focused Therapy is a relatively new therapy with a different emphasis than traditional whose main focus is the examination of an underlying cause for a problem (e.g. Cognitive Therapy, Psychoanalytic Therapy, and Adlerian Therapy). Solution-Focused Therapy is gaining popularity, in part, because Managed Care requires fewer client sessions. Also, some therapists find it frustrating to attempt to use a diluted, short-term version of a traditional therapy. For this reason many therapists who have been working from a traditional perspective may now be examining the possibilities that Solution-Focused Therapy has to offer.

The purpose of this paper is to provide an overview of the Solution-Focused Therapy philosophy, including some of its basic assumptions and their application in therapy. In doing so, the history of the development of Solution-Focused Therapy will be examined. Covered in this review is a summary of some of the elements borrowed from Social Constructionism and traditional therapies. The underlying assumptions of Solution-Focused Therapy to be examined include its focus on strengths, its particular view of reality (especially in regard to how expectations and the use of language affect outcome), and understanding change. The therapist's conceptualization of the client and the therapist's role will also be examined, as well as purported limitations of Solution-Focused Therapy.
Some ways of minimizing these stated limitations will also be discussed.

Overview of Solution-Focused Therapy's History and Development

Insoo Kim Berg, Steve de Shazer, and their colleagues at the Brief Family Therapy Center (BFTC) pioneered Solution-Focused Therapy in Milwaukee, Wisconsin (Berg & De Jong, 1996). The assumptions, structure, and procedures of Solution-Focused Therapy were developed through the observation of many client sessions over a 20-year period. When this group started, their plan was to develop and teach a brief family therapy model based on the work of Milton Erickson and Gregory Bateson, as the Milan and Mental Research Institute models had done (Lipchik, 1992).

The Brief Family Therapy Center, however, shifted the emphasis of therapy away from the Mental Research Institute's approach of identifying client's patterns of functioning in order to interrupt the problem sequence (Berg & De Jong, 1996). Instead, the pioneers of Solution-Focused Therapy began to focus on what has worked in the past for the client, with emphasis on repeating their solution (O'Hanlon & Weiner-Davis, 1989). They shortened the problem exploration phase and placed more emphasis on the times when the problem was not present, noticing pre-session change as well (Quick, 1996). The assumption was that if change was already occurring in the client's desired direction, therapists did not need
to initiate change, but only encourage its continuation (Quick). Another shift from the Mental Research Institute’s approach, was that Solution-Focused Therapy pioneers began to pay less attention to how a problem was maintained. Rather, they put more emphasis on “doing something different” (de Shazer, 1988, cited in Quick). Less emphasis was placed on the elimination of symptoms, and more on the achievement of a specified goal (Quick).

Social Constructionism underlies Solution-Focused Therapy. Social Constructionism is defined as a “metatheory about people’s interpretations of the world and their experiences” (Berg & DeJong, 1996, p. 388). It examines the way people create meaning influenced by their culture, social environment and personal perspective. Some assumptions that may emerge from this perspective include a view of reality as created through conversation, personal interpretation, and mutual consent (Hoffman, cited in Berg & DeJong). The premise is that clients change by making new decisions based on “changes in perception, patterns of interacting and living, and meaning” (Berg & DeJong, p. 377). In addition, both Social-Constructionism and Solution-Focused Therapy view clients as experts regarding the meaning they attach to events (Berg & DeJong). Other phenomena borrowed from Social Constructionism include the use of reflective questioning, an emphasis on clients’ strengths, and the
co-construction of solutions (Berg & DeJong).

Solution-Focused Therapy was influenced by other therapies, especially family therapy, and techniques derived from Milton Erickson's and Jay Haley's work (de Shazer, 1985; Johnson & Miller, 1994). One principle Solution-Focused Therapy borrowed from Erickson was finding a solution for the individual rather than treating all people with similar complaints the same (Berg & Miller, 1992). Erickson did this by working within the client's frame of reference, using knowledge of clients' life-learning, mental skills and experiences when helping them come up with solutions.

Solution-Focused Therapy is reminiscent of Cognitive Therapy in its emphasis on clients meaning making (Beck, Rush, Shaw, & Emery, cited Johnson & Miller, 1994) but uses more of a process of perspective taking then examination of thought processes (Walter & Peller, 1992). Solution-Focused Therapy helps clients move to a perspective that is focused on the solution instead of working within a problem correcting focus.

Solution-Focused Therapy emphasizes goals as does Behavioral Therapy but pursues them differently (Martin & Pear, cited in Johnson & Miller, 1994; Turner, Calhoun & Adams, cited in Johnson & Miller). In Solution-Focused Therapy, goals and the means to meet them are taken from the clients' knowledge (Walter & Peller, 1992; Mahrer, 1995; de
Shazer, 1985) as opposed to Behavioral Therapy's assumption that clients must learn to obtain goals (Corey, 1991a; Corey, 1991b).

An additional similarity between Solution-Focused Therapy and cognitive-behavioral treatment is the use of skill-building psychoeducational techniques (Beck et al., cited in Johnson & Miller, 1994). Solution-Focused Therapy does not teach skill-building psychoeducational techniques. Instead Solution-Focused therapists clients build their skills, with the help of therapist's questioning past successes. Clients observe and analyze when the situation is or has been the way they wanted it to be, where the problem behavior is not present or is less. Thus, in this way they gain valuable information about themselves and how they have handled the difficulty. This is the information they need in order to repeat the desired behavior (Molnar & de Shazer, 1987; O'Hanlon & Weiner-Davis, 1989; Berg & de Shazer, 1993).

The interview is key to Solution-Focused Therapy. According to Johnson and Miller (1994), the therapeutic interview, which is characteristic of other therapies (the authors do not specify which ones), is also a significant intervention for Solution-Focused Therapy. The difference for Solution-Focused Therapy in the use of the interview, however, is the form of questions it uses, and the fact that the therapist rejects the use of interpretation or confrontation (Johnson & Miller). For
instance, the reflective questioning used in Solution-Focused Therapy help clients view themselves from the outside by reflecting on how others see them or how they function in a certain context (Johnsson & Miller). Other types of questions include the "miracle question," "scaling questions," "coping questions," and "exception questions" (Berg & DeJong, 1996; Berg & Miller, 1992). These will be discussed in the application section of this paper.

Basic Philosophical Assumptions of Solution-Focused Therapy

Emphasis on Mental Health versus Mental Illness

Berg (1994b) asserts that Solution-Focused Therapy is not "a bag of tricks," it is an "expression of an attitude, a posture and a philosophy" (p. 14). It is a "context the therapist offers the client for evolving new meaning, new ways of looking at the vexing problems" (Berg, p. 13). The conceptual framework Solution-Focused Therapy offers encourages a focus on "productive, useful, positive behavior, with a corresponding deemphasis on and skepticism about current conceptualizations of mental disorders" (Fish, 1996, p. 37).

O'Hanlon (1993) asserts that traditional therapy, in contrast to Solution-Focused Therapy, tends to be pathology-oriented with the presenting concern being expressed as a function of some underlying individual or social dysfunction or illness (depending on the therapy). The
emphasis in these therapies tends to be on gaining a better understanding of the "maladaptive, problem-solving behaviors" by discussing and pursuing the function of the symptom(s) (Jordan & Quinn, 1994). The next step involves therapists operating on clients to cure or heal them (Berg & de Shazer, 1993; de Shazer, 1993a, 1993b). The goal of Solution-Focused Therapy, however, is not to act as a cure for an illness (Walter & Peller, 1992). Instead, therapy is perceived as a process whereby the therapist and the client work together to discover, invent or apply solutions (de Shazer, 1993b). Unlike family therapy tradition (which is an antecedent of Solution-Focused Therapy) where the family is usually designated as the patient, brief therapy tradition (which includes Solution-Focused Therapy), characterizes the problem/solution as the "patient" (a word used for comparison purposes only) (de Shazer, 1993a).

Furthermore, clients are seen as having the necessary strengths and skills needed to change their situation and get themselves back "on-track" (Berg & De Jong, 1996).

**Focus on the positive.** Rather than focusing on the exploration of the negative details of the problem or dysfunction, Solution-Focused Therapy focuses on redirecting the conversation back towards problem-solving strengths (Weiner-Davis, 1993; Berg & DeJong, 1996). It leads the client away from a perspective that emphasizes the negative "pole" of
experience (i.e. limitations and deficiencies), to a more positive perspective (Saleebey, cited in Berg and DeJong, 1996), in an intentional and disciplined manner (Berg & De Jong). According to O'Hanlon and Weiner-Davis (1989), Solution-Focused therapists oppose the idea of pathologizing and objectifying clients. They do not blame clients or give them stigmatizing labels. Focusing on negative behaviors, according to Walter and Peller (1992), facilitates feelings of shame and acts more as a deterrent to change. A strategy of Solution-Focused Therapy is focusing on clients' strengths. Walter and Peller (1992) and, Weiner-Davis (1992) argue that this is more effective than dissecting their weaknesses. The underlying assumption is that when clients feel more empowered, they act more creative and capable. Thus, they are more likely to have a renewed sense of energy for finding their solutions (Weiner-Davis).

Solution-Focused therapists take clients' issues at face value and do not assume or attribute an underlying problem or complicated meaning to their situation or words (Weiner-Davis, 1992). They assume that clients are capable of creating what they want in their lives (Walter & Peller, 1992) by emphasizing workable aspects of clients' lives (O'Hanlon, 1993).

In summary, evoking clients' strengths, abilities, and resources can lead to changes in clients' actions and viewpoints (O'Hanlon & Weiner-Davis, 1989; Berg & DeJong, 1996).
Constructing stories of success. From a Solution-Focused Therapy perspective, a problem cannot be solved with the same kind of thinking that has created that problem (Berg & de Shazer, 1993). For this reason, Solution-Focused therapists look at what does work instead of concentrating their efforts on the cause of the problem. Clients are invited to recognize and then build on what they are already doing successfully, or more effectively in handling the problem (Cade & O'Hanlon, 1993). As described in an earlier section, in order to facilitate change in the desired direction, Solution-Focused therapists examine the times when the desired behavior occurred in the past and look for ways to repeat it in the future (Walter & Peller, 1992; Cade & O'Hanlon, 1993; Weiner-Davis, 1992). Solution-Focused therapists also highlight success or degrees of success by emphasizing and questioning clients about what they have done to cope under duress (Cade & O'Hanlon). For the Solution-Focused therapist, success means a “reported and/or observed change in behavior within the complaint pattern and the end of the complaint (i.e. the ‘symptoms’ stopped)” (de Shazer, 1985, p. 21).

View of Reality from a Solution-Focused Therapy Perspective

Many therapies, from Freud to Selvini Palazzoli to Minuchin are based on structural thinking, the premise that there is an objective truth or some hidden meaning in language which can be grasped by looking
behind and beneath the words (Berg & de Shazer, 1993). This review has already discussed the difference between Solution-Focused Therapy and traditional therapies, where the main focus is the examination of an underlying cause to the problem, pathologizing and possibly objectifying clients. Further details about how therapist’s perception of language and expectation for outcome affects reality will be discussed in the following two sections.

The effect of language on reality. Solution-Focused Therapy is based on a poststructural view which assumes that “language is reality” (Berg & de Shazer, 1993, p.7). Proponents of this philosophy assume that there is a physical reality or hidden truth out there, but that our social reality is negotiated through language and interaction (O’Hanlon, 1993). De Shazer (1993b) describes “therapy as conversation,” an interaction between two or more people, which happens within language. From this perspective, therapy is seen as a process whereby, instead of looking behind and beneath the words used, therapists and clients use language as a tool. “Therapy needs to be seen as always happening in language” (p. 83). Berg & de Shazer believe that we confuse who we are with the words that are being spoken. In any conversation, the listeners are translating what they think they hear and using this information to define the person or the problem. In reality, the listeners are only prescribing onto
the words their own meaning of the author’s true intentions. De Shazer (1993b) asserts that it is impossible to arrive at any one “true” meaning for any word. For him, meaning is negotiated between the therapist and the client. Therefore, therapists’ expectations of their clients influence the outcome of therapy and how change happens. In other words, if a therapist believes clients are sick, many things clients say will be translated to confirm this belief.

The effect of expectations on outcome. Solution-Focused therapists embrace the position that there is no predetermined way to objectively view clients through scientifically acquired knowledge or to solve their problems by using reason, independent of experience (O’Hanlon & Weiner-Davis, 1989; Berg & DeJong, 1996). Consequently, they do not search for a norm that clients should conform to, or other “static, fixed psychological/emotional entities” (O’Hanlon & Weiner-Davis). O’Hanlon and Weiner-Davis assume that reality is not static and fixed but is influenced by one’s culture and interactions with others. As a result, O’Hanlon and Weiner-Davis focus less on the clients’ underlying problems or negative feelings, but rather lead clients to actively create the experiences they want. It’s not that therapists agree with everything their clients say. They challenge negative perceptions through the use of “exception” or “coping” questions (for instance), or they ignore client’s
negative feelings when appropriate and help them move towards their goals instead. This, then, changes the focus towards the goal or past successes.

Solution-Focused therapists are aware that their expectations influence the outcome of therapy (O'Hanlon & Weiner-Davis, 1989). According to O'Hanlon and Weiner-Davis, clients look for contextual cues from the therapist or counseling environment when determining how to act or what to share. For this reason, it is important to note what message the therapist is sending because it influences how clients view themselves and how they change. Therefore, therapists maintain those assumptions that empower clients, enhance client-therapist cooperation, and make their work together enjoyable and effective (O'Hanlon & Weiner-Davis). They do this by attempting to define the structure of clients’ situations as productive, and as something that will continue to be worthwhile (Molnar & de Shazer, 1987). They expect that since the client has coped in the past, he or she can use those skills to cope in the future. These assumptions, with its focus on possibilities and strengths, can help create self-fulfilling prophecies (O'Hanlon & Weiner-Davis).

**Understanding Change**

Weiner-Davis (1992) asserts that most clients want to change, but are not quite sure of how to go about it. In her opinion, Solution-Focused
therapists look at unproductive ways of behaving as bad habits that can be changed. Solution-Focused therapists do not attribute malice or negative intent to their clients. Rather, they assume that clients simply have not yet become aware of an alternate response (Weiner-Davis).

Solution-Focused therapists have expectations that long lasting change can happen quickly (Weiner-Davis, 1992) even with problems that have been dominating the client's world for a while. They assume that changes are likely, until proven otherwise. Because of this, the therapist starts the session with the question, "What would you like to change?"

Most Solution-Focused therapists consider change as a constant (O'Hanlon and Weiner-Davis, 1989; Walter & Peller, 1992). They assume that change is happening all the time. In other words, if change is happening all the time it must be taking place in the client's situation as well. It is essential in Solution-Focused Therapy that therapists allow this assumption to permeate their verbal as well as non-verbal behavior (O'Hanlon & Weiner-Davis). Solution-Focused therapists attempt to give the impression that it would be surprising if the presenting complaint persisted. Consequently, they do not believe that it is useful to explain the transitions or how the problem was maintained (Walter & Peller).

Solution-Focused therapists believe that change is inevitable and that small changes lead to larger changes (Walter & Peller, 1992). They
believe that no matter how complex or disastrous the situation, a small change in one person's behavior can make a far-reaching and profound difference in the behavior of all persons involved (de Shazer, 1985; O'Hanlon & Weiner-Davis, 1989).

The Therapist's Conceptualization of the Client

Solution-Focused therapists view their clients as competent at conceptualizing an alternative more satisfying plan for the future (Berg & DeJong, 1996). They perceive that clients have the necessary problem-solving skills to resolve their problems by locating within themselves, strengths and resources they can use to make this plan a reality (Weiner-Davis, 1992; 1993). They believe that clients know themselves best and are showing them, by their actions, how they think change takes place (Weiner-Davis, 1992). Therefore, since there is no one valid or correct way to live one's life, their clients are expert on what needs to change for them (O'Hanlon & Weiner-Davis, 1992), the meaning they attribute to an event, and their past successes (Berg & De Jong). Thus, Solution-Focused therapists collaborate with clients in establishing goals to be accomplished in treatment (O'Hanlon & Weiner-Davis; Nylund & Corsiglia, 1994).

Solution-Focused therapists believe that clients have their own unique ways of cooperating (O'Hanlon & Weiner-Davis, 1989). They
consider cooperation from the client to be inevitable (Walter & Peller, 1992; Berg, 1994a; Nylund & Corsiglia, 1994). Unlike many problem-focused therapies where clients need to adhere to an external norm or be considered resistant, Solution-Focused therapists do not consider their clients resistant because their ideas of change differ from the therapist’s (Walter & Peller). Resistance, according to de Shazer (1989), is a therapist’s concept that has nothing to do with the client. De Shazer, along with other therapists, considers resistance to be a product of some problem-focused therapists who disregard their client’s frame of reference and impose their goals, values, or agenda on them (Berg, 1994a, 1994b; Nylund & Corsiglia, 1994). For instance, when clients do not follow through on homework, Solution-Focused therapists do not see this as resistance, but as a message from clients about how they think change takes place (de Shazer, 1985). In this case, the therapist might ask questions to assess how this action has contributed to their clients goals for therapy and what other actions might be needed for the to stay “on-track.”

The Therapist’s Role

Solution-Focused therapists do not see their job as diagnosing what is wrong, removing some personality flaw, or setting the course of treatment (Walter & Peller, 1992). They relinquish the role of expert or
teacher to the client, taking on a non-hierarchical facilitative role where the therapist both co-creates goals with the client as well as attempts to learn more about the client’s worldview (Berg & Miller, 1992; Berg, 1994b). Mindset is important in Solution-Focused Therapy. De Shazer (1993b) views therapy as “a mutual, cooperative, collaborative conversation between two or more experts” (p. 89). Solution-Focused therapists assume an “atheoretical, nonnormative, client-determined posture” (Berg and Miller, p. 7).

It becomes the therapists' job to understand clients’ thinking and act accordingly (Berg & DeJong, 1996). As in other therapies, Solution-Focused therapists attempt to uncover clients’ perceptions and meanings, and to understand their past experience, and definition of reality (Berg & DeJong). They also attempt to stay in sync with clients, and to work in collaboration by taking into consideration client’s frame of reference and what they are ready to change (Duncan, Hubble & Miller, 1997). This influences their thinking and how they converse with their clients (Walter and Peller; 1992; Berg & De Jong). Solutions are constructed interactively, with all views equally valid (Walter & Peller, 1992). Therapists need to avoid confrontive techniques, and remain non-judgmental and accepting, which will encourage an accepting frame of mind in clients (Kiser, Piercy & Lipchik, 1993). This, in turn, will allow clients to create their own solutions
that are congruent with their way of conducting life (Berg, 1994a, 1994b).

Application of Solution-Focused Therapy Assumptions

Solution-Focused therapist’s principle task is to help clients develop clear, concrete treatment goals (Jordan & Quinn, 1994) by emphasizing what clients would like to change (O’Hanlon & Weiner-Davis, 1989). Thus, Solution-Focused therapists focus on what seems to be working in the client’s life (no matter how small the success) and, label it as worthwhile and amplify it (O’Hanlon & Weiner-Davis; Nylund & Corsiglia, 1994). Little time is spent explaining the cause of the problem’s existence (Berg & Miller, 1992). Instead, Solution-Focused therapists’ job is to assist clients in changing how they perceive the problem (Weiner Davis, 1993) by selecting and identifying those changes, meanings, or ways of being that they would like to see continue (Berg & Miller). Therapists do this by eliciting positive alternatives in problematic situations (Berg & DeJong, 1996).

Weiner-Davis (1992) focuses on times when the desired behavior occurred in order to repeat the process. She believes that this is focusing on a client’s strengths and it helps them obtain new perspectives. This practice not only empowers clients, it also demonstrates to them that they can change because they already have. Their behaviors, then, are not the result of deeply ingrained personality characteristics but rather are
triggered by specific conditions and contexts (Weiner-Davis).

It is the Solution-Focused therapist's responsibility to ask questions that will indirectly reframe clients' frame of reference and help establish goals (Gingerich, De Shazer & Weiner-Davis, cited in Johnson & Miller, 1994). Such questioning includes the miracle question, scaling questions, and exception questions (Berg & DeJong, 1996). Questions that evoke clients' perceptions of what they would like to be different in their lives include the miracle question. The miracle question is used to "define client's goals and illuminate the hypothetical solutions" (de Shazer, cited in Berg & de Shazer, 1993, p. 9). ["Suppose that tonight after you go to sleep a miracle happens and the problems that brought you to therapy are solved immediately... how will you discover the miracle has happened?" (de Shazer, 1994, p. 95)]. Questions that elicit clients' perceptions and definitions (Berg & DeJong) include scaling questions. Scaling questions ("On a scale of 1 to 10...") are used to clarify client's meaning, perception, motivation, and goals (Berg & de Shazer; de Shazer; Berg & Miller, 1992).

The co-construction of a sense of competence with clients is also important (Berg & De Jong, 1996). Exception questions are used for this purpose, to elicit client's strengths, which helps provide clinical direction (Berg & Miller, 1992). Johnson and Miller (1994) define exceptions as "times when the problem behavior is either absent, less or dealt with in a
manner that was acceptable to the client" (p. 246). The exception question asks, "Is there a time when the problem behavior is less or not present?" Solution-Focused therapists help clients gather information about what elements are present in those situations which clients could repeat (O'Hanlon & Weiner-Davis, 1989). All these questions, along with coping and pre-session change questions, are asked by therapists within an explicit mindset or framework of Solution-Focused Therapy (Walter & Peller, 1992; Berg & Miller).

Limitations of Solution-Focused Therapy

As was mentioned in the history section, Solution-Focused Therapy is a relatively new therapy. There are only a few journal articles written which address the limitations of the Solution-Focused Therapy approach. Research on this therapy is almost non-existent. The limitations listed here, hopefully, embrace the key criticisms.

One of the principles that makes Solution-Focused Therapy appealing to some therapists and clients is that they do not have to look for some underlying cause to the problem, and can go rather quickly to the solution. This process can have a negative outcome when therapists expect their clients to talk only about solutions, and not the problem, to the point where the client feels unheard (Nylund & Corsiglia, 1994). Some people consider this a limitation of Solution-Focused Therapy. Indeed,
some reasons for this to occur are that some therapists are too concerned with striving to make changes (Nylund & Corsiglia) emphasizing solutions (Weiner-Davis, 1993) or eliciting examples from clients of times when the problem behavior is not present. Other therapists may too quickly attempt to shift the emphasis from the client's emotions to the observable behaviors that accompany them (Kiser et al., 1993; Weiner-Davis). In these cases, they may not perceive their client's reality accurately.

Since Solution-Focused Therapy is a simple therapy, some therapists may criticize it as being too simplistic or superficial, minimizing the real hardship of the problem, not getting to the depth of the problem, or neglecting to take action to directly alter a harmful or difficult condition (O'Hanlon, 1993). O'Hanlon warns against the possible conceptualizations of Solution-Focused Therapy as simply positive thinking. The confusion stems from therapists' enthusiastic intentions to move clients, according to Kiser et al. (1993) (based on work done by Bower), from a state of "affective congruence," to one of "affective incongruence." That is, they argue that the focus of Solution-Focused Therapy is to take clients' from a negative state of emotion that matches their negative experience, to an emotional state whereby clients' emotions need to shift to something more positive while they are still feeling bad. Some therapists translate this transition into a practice which portrays the therapy as a "gung ho," "You-
can-do-anything-you-set-your-mind-to," New-Age Pollyanna view of life, a sales technique for motivating clients, that assumes that anything can be yours if you write enough affirmations (O'Hanlon).

Rebuttal to Possible Limitations

Many Solution-Focused therapists would disagree with these stated limitations (i.e. that clients feel unheard, or Solution-Focused Therapy is a superficial therapy which minimizes clients' problems). In rebuttal to the first limitation, that clients feel unheard, Nylund and Corsiglia (1994) suggest that therapists refrain from arguing for their own perception and pursuing their own goals about what needs to happen in therapy. It is important to be in sync with clients. For those clients who feel cut-off or unheard by the Solution-Focused therapist, it is important that more time is spent discussing the details of their story about the presenting problem (Weiner-Davis, 1993). Weiner-Davis (1992) reports that she does not ignore emotions but finds that clients who come to therapy oftentimes have already spent a great deal of time feeling emotionally off-balance. In many cases, she feels she can make a greater difference to them if she focuses their attention away from their emotions, and onto solutions.

Kiser et al. (1993) believe that the Solution-Focused Therapy approach needs to incorporate more time discussing and processing
clients' emotions. They caution against ignoring clients' emotions in an effort to encourage change before the client is ready. Too often, these authors warn, Solution-Focused therapists fall in the trap of trying to move clients towards an imagined future without allowing them the needed time to make this change. They assert that there are times when clients are not ready to give up these emotions as a way of protecting themselves from further pain or disappointment. These authors suggest that there are some questions that therapists can use to overtly address clients' negative emotions and help them put their problems into perspective, and yet still keep with the spirit of Solution-Focused Therapy. Once therapists understand the problem better, they can help clients look for solutions (Weiner-Davis, 1993).

Regarding the limitation of Solution-Focused Therapy being simplistic or superficial, O'Hanlon (1993) suggests that Solution-Focused therapists stay away from positive thinking concepts that tend to minimize the negative physical events and struggles that clients encounter. He defines the positive shift that occurs in Solution-Focused Therapy as more than just reframing, shifting paradigms, or using techniques that do not directly alter the client's difficult or harmful conditions (O'Hanlon).

Walter and Peller (1992) and, Berg and De Jong (1996) suggest that there is an underlying focus to Solution-Focused Therapy in the form
of questions and type of questioning used as well as the mindset the therapist embraces. Sometimes therapists will ask questions in an instrumental manner. Nylund and Corsiglia (1994) suggest that therapists do more than ask questions, but take into consideration the emotional context, pacing of the interview, and the client's body language. Berg (1994b) argues that a therapist's lack of success in using this approach to therapy may be due more to a lack of listening skills, faith in clients to know what's best for themselves, or misunderstanding the "philosophical thinking" that underlies the questioning used in Solution-Focused Therapy. Some therapists think of this as a limitation, when in reality it is simply confusion regarding Solution-Focused Therapy's goal. Solution-Focused therapists' job is, not to fix their clients, but to help them create new meaning and new ways of looking at their problems. Berg asserts that Solution-Focused Therapy is more than a handful of questions, but an "expression of an attitude, a posture and a philosophy" (p. 14).

Conclusion

The purpose of this paper was to examine the philosophy behind Solution-Focused Therapy, examining both its strengths and limitations. Much time was spent discussing the history of Solution-Focused Therapy, and its underlying assumptions. Solution-Focused Therapy, like other therapies, has limitations especially when care is not taken to
acknowledge and validate the client's frame of reference, strengths, assets, and view of how change takes place. Some schools of thinking believe that therapists need to go into the clients' past, where the problems began in order to "fix" them. Solution-Focused Therapy, on the other hand, is present and future oriented, the past is not emphasized. Not delving into client's past and going more directly to solutions may be appealing to some therapists and clients, and may be an effective therapeutic move. However, there has been little research comparing this type of therapy with Solution-Focused Therapy, leaving this author with more questions than answers.

On a different note, it appears that Solution-Focused Therapy mindset is interesting when used as a way of showing respect to clients and the wealth of knowledge they possess. It may also be useful when used as a tool to increase trust between the therapist and client, and decrease clients' shame and obsession with the negative thinking that keeps them pinned under the weight of their problems.
References


