
BRIEF
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Some recent Emails again brought up a topic that is on one hand
"dear-to-my-heart
and on the other hand "a-pain-in-the-ass." It is not the first time that I have been
asked, although I hope it is the last, to explain the difference(s) between "brief
therapy" and "solution-focused therapy."

I

I must start with the most simple response first: "Solution-focused
therapy" exists only because some people did not want to use the term "brief"
which was in the original name - > Solution-focused brief therapy.

Solution-focused brief therapy is part of a tradition of "brief therapy"
which evolved from the work of Milton H. Erickson through the work of John
H. Weakland and his colleagues (focused problem resolution), Jay
Haley's (so-called) strategic therapy, and our own, early problem-focused
work (between 1970 and 1982). In the original name, "solution-focused"
is used to distinguish and mark a type of "brief Therapy."
Grammatically, "solution-focused" modifies the noun "brief therapy". The
development of "solution-focused therapy" is an unintended mutation; a term
which is often meant to be more general and thus more fitting for some
contexts in which the term "brief therapy" would make for unintended
difficulties.

For me, when speaking about my own clinical work, the full original label
is required because it seems necessary to spell out the ethical imperative
for minimal intervention that is implied in the term "brief." For me, the
term "brief" is not a limiting notion (in terms of number of sessions, etc.)
except that it means "as few sessions as possible, not one more than
necessary." Thus I am always asking the client - as soon as the client
mentions significant change - whether or not things are "better enough"
for therapy to end. Obviously, this promotes brevity.

II

The questioner may have been asking a different question, wondering about the differences between MRI style "Brief Therapy" which was developed by John Weakland, Dick Fisch, and Paul Watzlawick" and "Solution-focused therapy". Obviously, the better comparison is with Solution-focused Brief Therapy. MRI style BT is SFBT's closest relative. The two models are much more similar to each other than either of them is to any other model of therapy. Both models were developed out of the work of Milton Erickson and share many points, the ethic of minimal intervention being only one of them.

One of the main feature of BT is the observation that problems involve self-maintaining behaviors. For instance, if a person feels down, then other (significant) people will attempt to cheer him up. Frequently this does not work and the person (who also knows he should cheer up but "can't") becomes depressed. His friends increase their efforts to cheer him up. These too fail and he becomes more depressed. A vicious circle develops. That is, these attempted solutions (efforts to cheer him up that do not work) not only fail but they become part of the problem and part of what is maintaining his depressed feelings.

According to the interactional view, such a depression is really an interactional problem. Thus, if the friends stop trying to cheer him - and instead recognize his bad feelings but suggest that he should perhaps be more realistic and be more down - there is a good chance that he will start to feel angry, which is not a depressed feeling. Therapy, based on the interactional view, might involve either the person with the depressed feelings or a significant other person who is wanting to help. When the person feeling depressed comes to therapy, the therapist will take this kind of a position: it is clear that the client should be more depressed.

All problems are seen to have similar self-maintaining properties and thus the therapist wants to find out what the client is doing to attempt to solve the problem that has failed. Clearly these attempts need to stop and - as an intervention, the therapist may suggest an 180 degree turn, i. e., doing the opposite.

III

SFBT, while seeing problems in much the same way, is based on the observation that no problem happens all the time. That is, a person who is feeling

down at one time does not always feel down. Nor do his friends always repeatedly try to cheer him up. What is he doing when he is not feeling down? How are his friends reacting to his down feeling when they do not try to cheer him up? Therapy, again based on the interactional view, might involve either party. In this situation, SFBT is most interested in what the client will be doing different and how the other people around him/her will be reacting when the client is no longer depressed. Once it is more or less clear what the client will be doing instead of being depressed, the therapist and client will work on getting that to happen – and little or no effort will be put into helping the client to stop being depressed since – when he is doing something instead of doing what he does when he's epressed, he's not depressed.

IV

Thus the primary difference between Brief Therapy and Solution-Focused Brief Therapy is that BT focuses on stopping the problem (the interactions between the client and others that accidentally maintains the difficulty) while SFBT focuses on initiating the solution (the interactions between the client and others that happen instead of the difficulty).

A RECURRING THEME

Steve de Shazer, February 2000

THE WRONG QUESTION: Over and over in seminars and workshops as well as on the SFT-List, a question is asked in the following form: How do you, or, How does SFBT, treat "X"? The meaning of "X" depends on the questioner's special interest and knowledge or on what is currently the "hot topic" of the month, or sometimes simple curiosity. It might be that X=alcoholism, or X might =depression, or it might =domestic violence. What X means does not really matter because the form of the question makes it into the same "wrong" question and attempts to give an answer will lead to a muddle at least if not to some gross misunderstanding.

Let's be clear about this. Words like "alcoholism," "depression," and "domestic violence" are all concepts. Thus my (overly) simple answer

is "I don't know. I've never treated a concept." This answer can easily be misunderstood in some not very useful ways and I am often seen as "terse" or even as "being difficult". Obviously, for a questioner who strongly believes that alcoholism is a disease (the concept of disease is frequently a concept within the concept of alcoholism - which is, perhaps, already a Theory), it sounds as if I am dismissing what is for him or her a very serious question indeed. When I say this sort of thing I try to do so with a humorous manner but, alas, I am not always successful. This is, after all, not a joking matter: alcoholism is a serious business.

This is the crux of the matter. This is one of the points that marks the distinction between SFBT and other, more traditional approaches. I will ask my questioner for a specific case to talk about, which we can use to illustrate my approach since it is necessarily different for each and every case that the questioner might have in mind when asking about "alcoholism." When all goes well (which is not often) he or she has a specific case in mind which, through our conversation, we can construct as not really treatable within the concept of alcoholism. For instance, the client may not be interested in changing his drinking pattern but his wife wants him to. (A very typical position for clients to take.) But, I ask my questioner, what does he (the client) want from therapy? All too often the questioner won't know what the client wants although he knows what the wife wants and what is demanded by the Theory of Alcoholism - complete and total abstinence. Most often this is exactly what the client himself does not want! (Guess what? Most likely, he wants to drink like other normal people do.) At this point Theory and SFBT are in conflict and effective SFBT demands we drop the Theory. If we do not, then the client will (rightfully) resist our efforts to help him make a change he does not want to make - a fact which is obvious to the questioner once our conversation gets to this point. (For instance, research tells us that abstinence only treatment programs succeed @ 7% of the time - which means they fail 93% of the time.)

At this point we can begin to speculate about how this particular client might respond to the Miracle Question so that we can begin to figure out what he might want from the therapy rather what he does not want. I can, of course, make suggestions about how I image this client might respond

based on many, many cases. It is clear that this client wants to please his wife. Otherwise he would not have allowed himself to be forced into seeing a therapist! So, our conversation might focus on how the questioner imagines that the client would know that he had indeed pleased his wife. Furthermore, we can talk about the consequences for both of them of his pleasing his wife. Interestingly, while talking about this topic (wife pleasing) the client will probably not mention either drinking or non-drinking. A whole catalogue of ways the client would know that he had pleased his wife might be developed and then his changing his drinking pattern might be developed by the client himself as a means to that end. That is, changing his drinking pattern may become seen as a way to make his pleasing his wife more possible and more probable. My questioner is then sent home to ask the client the miracle question and to work on getting as useful a response as possible. He needs to find out what his client wants.

PEOPLE, NOT CONCEPTS. As I see it, I cannot treat concepts. SFBT is designed to treat people and concepts and Theory need to be excused from the therapy room. Of course this makes things difficult for me when dealing with traditionalists but while being clear about these issues may be difficult, the resulting difficulty is less than it would have been if I had tried to talk about treating a concept. I cannot treat alcoholism or depression or domestic violence (except in a paper such as this).

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