Solution Focused Therapy
Treatment Manual for Working with Individuals
3rd Edition

Solution Focused Brief Therapy Association Research Committee

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Solution Focused Therapy Treatment Manual for Working with Individuals 1st Edition

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TABLE OF CONTENTS

OVERVIEW

Introduction

This manual offers an overview of the general structure, techniques, and research support for Solution Focused Brief Therapy (SFBT). It follows a format suggested by Carroll and Nuro (2002) and Carroll and Rounsaville (2007). As these authors state, a treatment manual is especially useful for conducting outcome research and for preparing clinicians in the therapeutic approach. They also note the values of brevity and flexibility within an approach while also consistently providing pathways to the related literature in which users can discover more about the topics briefly addressed in the manual. In this manual of SFBT, we endeavor to respect these considerations.

Basic Tenets

SFBT is based on more than forty years of clinical practice, theoretical development, and empirical research (see, for example, Berg & Miller, 1992; De Jong & Berg, 2013; de Shazer et al.,1986; de Shazer, et al., 2007; Franklin et al., 2012; Korman et al., 2020; McKergow, 2021; Ratner et al., 2012). SFBT is in many ways different from traditional approaches to treatment. It is a competency- and resource-based model that minimizes focus on past failings and problems, and instead emphasizes clients' strengths and successes. The approach focuses on working from the clients' understandings of their concerns and situations and on what clients want different in their lives. The basic tenets that inform the approach are:

- It is based on solution building rather than problem solving.
- The therapeutic focus is on the clients' desired futures rather than on past problems or current conflicts.
- Clients are encouraged to increase the frequency of current useful behaviors.
- No problem happens all the time. There are exceptions, that is, times when the problem could have happened but did not or was less severe. Exceptions can be used by the clients and the therapist to co-construct solutions.
- The therapist helps clients identify alternatives to current undesired patterns of behavior, cognition, and interaction that are within clients' repertoires or can be co-constructed by the therapist and clients as such.
- Differing from skill building and behavior therapy interventions, the approach assumes that the beginnings of solution behaviors already exist for clients.
- It is assumed that small increments of change can lead to larger increments of change.
- Clients' solutions are not necessarily directly related to identified problems.
- The conversational skills required of the therapist to invite the clients to build solutions are different from those needed to diagnose and treat client problems.

ORIGINS & DEVELOPMENT

Steve de Shazer, Insoo Kim Berg, and their colleagues developed the techniques of SFBT during the late 1970s and 1980s at the Brief Family Therapy Center (BFTC) in Milwaukee, Wisconsin. Before forming BFTC in 1978, de Shazer and Berg had separately spent time at the Brief Therapy Center, a part of the Mental Research Institute (MRI) in Palo Alto, California. The MRI model, grounded in the family therapy movement, was devoted to developing effective and efficient therapeutic interventions. The model viewed the difficulties that clients brought to therapy as unsuccessful patterned attempts to resolve problems in their lives. After gathering information from clients about the details of their problems as well as family interaction patterns that might be supporting the problems, the therapist would offer therapeutic tasks intended to lessen or resolve client problems (McKergow, 2021). The practices at MRI were influenced by those of the creative psychiatrist, Milton Erickson. Erickson was well known for his unusual interventions with clients that often led to clients quickly resolving their problems. de Shazer, too, was fascinated with Erickson's intervention approaches and began trying to emulate what he thought Erickson was doing. In the process, de Shazer began designing and publishing articles about his own brief therapy interventions with clients (Korman et al., 2020).

By the mid-1970s, de Shazer and Berg had returned to Milwaukee, had married, and were employed at a large family service agency. As Berg stated, "our dream was to create the MRI of the Midwest" (De Jong, 1998). True to that goal and following the practices at MRI, Berg had a one-way mirror installed in her large office so that she, de Shazer, and their colleagues could observe cases firsthand. Later, when BFTC was formed, it too (with clients' signed permissions) used one-way mirrors and video recording so that client-therapist interactions could be observed and studied firsthand. Thus began the BFTC approach—collaborative conversations between colleagues about the *direct observations* they were making of cases through the one-way mirror or by reviewing video recordings of cases—to inventing its brief therapy practices.

Employment of this *modus operandi* of direct observation and collaboration soon led BFTC in new directions. This set of events is described in detail in several sources (De Jong, 1998; 2019; De Jong et al., (in press); de Shazer 1982a; 1985; 1988; Korman et al., 2020; Lipchik et al., 2012; McKergow, 2021). Among these events was the 1982 family case that seriously challenged the team's assumption at the time. As such, the team obtained a description of the problem's patterns before an intervention message could be designed (Hopwood & de Shazer, 1994, 2021). By the end of the first session with this family, its members had described 27 different problems, none of which seemed more important to the BFTC team than the others. In their discussion to determine the message to provide the family at the end of the session, the team set aside their previous practice of developing a problem-specific task and instead developed what came to be known as the "formula first session task (FFST)"; they said to the family: "Between now and the next time we meet, we want you to observe, in such a way that that you can tell us next time, observe

what happens in your life that you want to continue to have happen" (Hopwood & de Shazer, 1994, 2021, p. 71). Two weeks later when the family returned, they were able to concretely describe many experiences since their first session that they wanted to continue to happen. They also said that the problem that brought them to therapy was solved and that they did not have to return.

This case shocked and puzzled the team and led them debate whether this was an isolated case or other clients could make progress without the client's or team's knowledge of the problem or its patterns. As a result, the team designed a practice-related research project wherein new clients were given the FFST at the end of each first session—an approach that became customary at BFTC. de Shazer (1985, pp. 154-155) states that, among other findings, 89 percent of these new clients reported at their second sessions that something worthwhile had happened between the two sessions, and nearly two-thirds said that things were better for them. In addition, clients consistently could describe these worthwhile things in specific and concrete terms.

This approach of direct observation of cases, team collaboration, and practice-related research led to the invention of several other new techniques; "Exceptions," the "miracle question," "scaling questions," asking "what's better" in later sessions, and the "presession change question" were developed in quick succession, and by the late 1980s, all major techniques associated SFBT were in place (de Shazer, 1985; 1988; Weiner-Davis et al., 1987).

These techniques, then, were primarily inductively developed through direct observation of therapy sessions; they were not deduced from existing theories about how to do therapy. Indeed, as these new techniques were being invented, the BFTC team was reconceptualizing many common ideas about clients, client change, and therapy itself (Korman et al., 2020). Among these ideas were: 1) redefining "client resistance" as the therapist not yet finding a way to cooperate with the client (de Shazer, 1984); 2) shifting from viewing the family as a system to viewing the family and the team interacting together as a change promoting system in therapy (de Shazer, 1982a, 1982b); and 3) reconceptualizing therapy as "focused solution development" instead of "focused problem resolution" (de Shazer et al., 1986). By 1986, the BFTC team was defining its form of brief therapy as "*utilizing what clients bring with them to help them meet their needs in such a way that they can make satisfactory lives for themselves*" (de Shazer et al., 1986, p. 208). This definition capturing what BFTC was doing with its clients was remarkably different than that formed in 1978 at the MRI of the Midwest.

THERAPEUTIC PROCESS

Vandebos (2007) has commonly defined psychotherapeutic process as:

> "Whatever occurs between and within the client and psychotherapist during the course of psychotherapy. This includes the experiences, attitudes, emotions, and behavior of both client and therapist, as well as the dynamic, or interaction, between them." (p. 757)

The SFBT approach to the therapeutic process is unique in at least three ways. First, other approaches to process focus primarily on what happens within the client. For example, when defining "mechanisms of change" in psychotherapy, Nock (2007, p. 8S) included only psychological or biological processes and explicitly excluded the communication between the therapist and client. SFBT *equates therapeutic process with the therapeutic dialogue*, i.e., what happens between therapist and client (McKergow & Korman, 2009). The change process in SFBT is the therapist's and client's co-construction of what is important to the client, their goals, related successes, and resources. SFBT training and practice focus on the details of how this conversational process occurs by attending to the therapist's and client's moment-by-moment exchanges (e.g., Berg & Miller, 1992; De Jong et al., 2013; De Jong & Berg, 2013; de Shazer et al., 2007; McKergow, 2021).

Second, the SFBT approach to dialogue as the essential therapeutic process focuses on what is *observable* in the communication and social interactions between client and therapist. As will be illustrated below, the specific exchanges through a process called "co-construction" are observable (Gergen, 2023; Gergen & Ness, 2016), whereas global inferences or characterizations of therapeutic communication or relationships are not. Thus, the SFBT process focuses what the therapist says and does rather than their intentions. This commitment to systematic observation as the basis of what is and is not useful in SFBT dates back to its origins at BFTC in the late 1970s and 1980s. As indicated earlier, the early research at BFTC was exploratory and qualitative, involving intense observation of therapy sessions through the one-way mirror and reviewing of video recordings. Observers looked for when clients made progress (as the clients defined progress) and examined what the clinicians might be doing that was contributing to that progress. Through open and lively discussions, the team invented and experimented with the several new techniques that then became known as SFBT.

Third, SFBT was developed on an empirical foundation of language use in dialogue, supported by solid experimental research in contemporary psycholinguistic. Bavelas (2012) reviewed the persuasive experimental evidence for collaboration and co-construction of mutual understandings through language interactions between the participants in face-to-face dialogues. It is important to note in this research manual that the evidence base of SFBT started on a firm foundation in basic research. It is also important to note that, in this regard, de Shazer and Berg were likely influenced during their time at the MRI in Palo Alto by the interactional view of communication being developed there during the 1960s and 70s. Part of the MRI during those years focused on the academic and research study of communication, interaction, and systems theory (Watzlawick et al., 1967). A second part of the MRI, the Brief Therapy Center, applied and

refined many of these ideas about communication while developing their form of brief psychotherapy.

SFBT Therapeutic Process as "Listen, Select, and Build"

In SFBT, the therapist and clients engage in a process of co-construction that results in clients' talking about themselves and their situations in new and different ways. Co-construction is a collaborative process in communication wherein speaker and listener collaborate to produce information together, and this jointly produced information acts to shift meanings and social interactions in clients' lives. The principles of this conversational process between therapist and client are the same regardless of the concern that each client brings to therapy. The conversation always focuses on what clients want to be different in their present and future and how to go about making that happen. SFBT is not an approach that has a long assessment phase that is meant to diagnose clients. In contrast, from the very beginning of therapy, SFBT therapists use a language of change that facilitates goal setting and client-centered solutions to problems. The signature questions and responses by therapists in solution-focused interviews are intended to initiate a co-constructive process which De Jong and Berg (2013), following the lead of de Shazer (1991; 1994; de Shazer et al., 2007), called "listen, select, and build."

In the "listen, select, and build" process, the SFBT therapist listens for and selects out the words and phrases from the client's language that are indications (initially, often only small hints) of some aspect of a solution, such as articulating what is important to the client, what they might want, related successes (e.g., exceptions), or client skills and resources. Once having made the selection, the therapist composes the next question or response (e.g., a paraphrase or summary) that aligns with the client's language and invites the client to build toward a clearer and more detailed version of an aspect of a solution. As the client responds from his or her own frame of reference, the therapist continues to listen, select, and compose the next solution-focused question or response, one that is built on what the client has said. It is through this continuing process of listening, selecting, and building on the client's language that the therapist and clients together co-construct new meanings and new possibilities for solutions. SFBT therapists also work hard to avoid assuming any "real or underlying meaning" behind clients' statements. Rather than interpreting hidden meanings, SFBT therapists focus on the clients' language, staying close to their words and exploring what the client means by the words they use.

The practice of listen, select, and build is illustrated in the following dialogue between a male solution-focused therapist and a young mother going through a difficult divorce and starting a new life with her 19-month-old son (De Jong et al., 2013). This excerpt occurred early in the session following introductions and began the co-construction of what the client might want from meeting with the therapist.

Dialogue #1

1 Therapist (T): So, umm. Is it okay if we start like, uh. [*pause*] What will have to happen, as a result of you [*gestures toward her*] coming here today – this afternoon, tomorrow, the day after tomorrow – for you to feel that it's been somewhat useful to, to be here?
2 Client (C): Um.
3 T: [*remains silent and settles into a listening posture, one hand holding his chin, looking directly at client*]
4 C: I don't think I'm—[*laughs, then gestures toward therapist with a slight shrug*]
5 T: [*nods*] It's a difficult question. [*gestures and returns to a listening posture*]
6 C: [*overlapping*] --am even looking that far ahead. [*looks down*] Um. [*long pause*]
7 T: [*stays in listening posture, remains silent*]
8 C: Maybe just [*pause*] to sort together everything I'm—
9 T: [*overlapping: tilts head to the right as if more interested, then poises pen to write*]
10 C: —feeling. I don't exactly know what that is yet.
11 T: [*overlapping: looks up, then nods several times]*
C: I don't…[*gestures with left hand towards the therapist*]
12 T: [*overlapping: nods*]
13 C: I don't exactly know what's bothering me, like—I mean I—
14 T: [*overlapping: nods continuously*]
15 C: I'm in the process of going through a divorce, so—
16 T: [*overlapping: nodding*]
17 C: I'm sure that's [*gestures toward him with both hands and then puts them on lap*] the majority of it.
18 T: [*overlapping: looks up at her, then*] Mm, Mm. [*while nodding*]
19 C: I just recently haven't been able to sleep too well, 'n—[*pause*]
20 T: [*overlapping: looks down, writes and nods*]
21 C: So, I thought maybe this might—[*pause*] help me sort out—whatever I need to—" [*while speaking, gestures between herself and him*]
22 T: [*overlapping: looks up at her as she says "might", then down to his notes, nods and says*] Right.
23 C: —to get my life [*slight pause*] back together. [*smile and slight laugh*]
24 T: [*looking down and writing as he talks*] Help you sort something out to get your life together. [*then nods and looks up at her; slight pause; then asks, while gesturing frequently toward her*] So what would be a feeling, ah, a thought, an action, something you would do or think or feel that would tell you that you were sort of getting your life together [*keeps looking at her*]
25 C: Umm—[*pause*]
26 T: —this afternoon or tomorrow? [*looks down and places pen as if to start writing; looks up and tilts his head as soon as she starts to speak*]
27 C: I guess like—just, relaxing maybe. [*gestures toward him*]
28 T: [*with big nod, looking down and writing*] Relaxing.

Research Support for SFBT Therapeutic Process

Beginning around 2000 and drawing on the findings of the psycholinguistic experimental research mentioned earlier (Bavelas, 2012), researchers began applying the methods of the microanalysis of face-to-face dialogue to therapy conversations, including SFBT therapy conversations. The purpose of this research is to investigate how face-to-face dialogue works and to make the process of co-constructing new meanings (such as solutions to client concerns) *directly observable*. Microanalysis is the moment-by-moment examination of the speech and co-speech acts in a face-to-face dialogue such as a therapy

(Bavelas, 2022; Bavelas et al., 2000). Microanalysis involves studying recorded sessions with both participants on screen throughout the recording so that the audible and visible actions of the participants can be simultaneously observed. Applying microanalysis, researchers have studied how clinician questions and formulations, i.e., paraphrases and questions, function and contribute to co-construction (McGee et al., 2005; Korman et al., 2013). They have examined how clinicians' positive and negative talk influence the way clients talk (Jordan et al., 2013). And, more recently, they have mapped and rendered the actual co-constructing between participants directly observable (Bavelas et al., 2017; De Jong et al., 2020). Co-construction occurs through a rapid, ongoing process of overlapping, three-step calibration sequences repeated one after another throughout the dialogue. Each sequence co-creates a new meaning, or mutual understanding, between the participants, with subsequent sequences building on previous ones. In their calibration analysis of a miracle question conversation, De Jong et al. (2020) mapped how the participants co-create a client's miracle picture through ongoing calibration that is both cumulative and coherent.

As we understand more and more how co-construction works in dialogues such as therapy, we are beginning to realize more clearly it is incomplete to think and talk about the co-construction in SFBT as the client's response to a given solution-focused (SF) question or formulation. While much of the research has been conducted on question-and-answer pairs and formulation-and-response pairs, a productive SF conversation involves skillfully linking these pairs in an ongoing process of inviting clients to build an ever-richer description of, for instance, what they might want different in their lives, their past successes, or their current level of progress. In a beginning effort to capture how SF question-and-answer pairs and SF formulation-and-response pairs are skillfully interwoven in a SF session, De Jong et al. (2024) proposed the notion of the "co-constructive sequence." A co-constructive sequence begins with an opening or framing question and continues with several related follow-up questions and formulations that invite the client to build in the direction set by the clinician's opening question. A good example is the *getting started* conversation between the therapist and his client in Dialogue #1. The therapist begins with his opening question: "What will have to happen, as a result of you [gestures toward her] coming here today—this afternoon, tomorrow, the day after tomorrow—for you to feel that it's been somewhat useful to, to be here?" He then uses his non-verbal actions, formulations, and follow-up questions to invite a more detailed and clear answer to his opening question. Notice that the sequence is 29 utterances, far longer than a simple question-and-answer pair. Each of the therapist's verbal and non-verbal acts after his opening question are an invitation to the client to construct a detailed response to the opening question of the sequence. It is useful for researchers, clinicians, supervisors, and trainers to zoom out from specific SF questions and consider conceptualizing SFBT practice in terms of co-constructive sequences. This practice is demonstrated in this manual through the presentation of the key parts of SF therapy along with examples of SF dialogues.

Theoretical Links

There are several extensive theoretical descriptions of how co-construction works. Once the key practices of SFBT were developed, de Shazer turned to writing extensively about how meanings develop and shift over the course of an SFBT dialogue (de Shazer, 1991; 1994; de Shazer et al., 2007). He called his collection of theoretical reflections "interactional constructivism." de Shazer's ideas are very similar to what is now commonly known as "social constructionism" (Gergen, 2023). Social constructionism is a theory that illustrates the ways a person's perceptions and behaviors are shaped in conversations and meaning is negotiated between others.

COMPONENTS OF SFBT

In 1990, de Shazer wrote a brief article describing what he took to be the core of SFBT. He provided:

> Most simply put, therapy is a conversation between at least two people (minimally one therapist and one client) about reaching the client's goal. The BFTC approach to this conversation is based on inducing doubt through search for and most often finding exceptions to the rule "It always happens" (de Shazer, 1988). If it is not always happening, then it is not really a problem after all and thus a different future becomes possible (success measured by goal achievement). Using this approach, I bypass even looking for a problem and look directly for any problem free times. Thus, I "ignore" the problem and work directly developing the solution. Tasks are based on using exceptions to help the client reach the goal. (pp. 98-99)

Essential Components

de Shazer's early description of SFBT, then, identifies the essence of SFBT to be conducting conversations with clients about *client goals* and *exceptions* and *progress* toward their goals. He described exceptions, i.e., non-problem times or better times, as "differences" in clients lives that they could use to develop solutions or the more satisfying lives they want. Later descriptions of SFBT, while somewhat altering and broadening the terminology, share the same essence of SFBT. For example, De Jong and Berg (2013) wrote that SFBT is about co-constructing with clients what they *want different* in their lives and how to make that happen. Making those desired differences happen involves co-constructing with clients their *successes* (i.e., exceptions) related to what they want different while, at the same time, regularly measuring their *on-going progress* toward what they want. Ratner et al. (2012) described SF practice as eliciting from clients their *best hopes* from meeting with the clinician; descriptions of their *preferred futures*; identifying *instances of success* that are already happening in their lives; and regularly asking about *client progress* toward their preferred futures. While SFBT treatment emphasizes client goals and exceptions and progress toward their goals, this does not mean that SFBT therapists are "problem phobic" or that they ignore or fail to validate the client's problem situation; alternatively, SFBT

therapists believe that positive change occurs through solution-focused conversation rather than problem-talk.

Complementary Components

Although not present every SF conversation or used by all SF clinicians, additional SF co-constructive sequences on certain topics are employed by SF clinicians as they often contribute to facilitating the changes that clients seek. Among these sequences are SF conversations about pre-session change, coping techniques, and session-ending feedback and tasks.

STRUCTURE & NUMBER OF SESSIONS

First Sessions

A minimalist map to first and later sessions is built around the essential components of SFBT. As SFBT revolves around a detailed description of what clients want different in their lives, initial sessions focus first on the clinician and clients co-constructing what the client might want different in their lives, i.e., goals or the preferred future. Additionally, it is important to first focus on clients' strengths and successes: *What are they good at? What do they enjoy doing? What are something that they are proud of themselves? Who are the important people in their family or lives?* A conversation on strengths, successes, and social supports engage clients in a positive direction prior to the goal construction process. Thereafter, the clinician and clients work on co-constructing any past successes, i.e., exceptions, related to what the clients want different. Then, the clinician measures the progress clients have made toward the goals or the preferred future, usually on a scale from 0 to 10. The first session ends with a summary of the goals and progress so far along with a suggestion of what clients might *do* and/or *observe for* in their lives that might be useful in maintaining and continuing their progress.

Later Sessions

All subsequent sessions involve co-constructive sequences around the same essential components of SFBT but in reverse order. That is, later sessions begin with a sequence around the "what's better [since our last session]" question. This question is simply another form of the exceptions question (i.e., a question about recent successes). Once the clinician and clients co-construct the details of the recent successes related to what the clients want, the clients' progress is measured on a scale from 0 to 10. Then, clients are asked what will be different in their lives when (or supposing) their number on the scale goes up one or two numbers. Co-constructing the details of what will be different when clients go up one or two numbers amounts to ongoing goal formulation, i.e., a further description of the preferred future. All later sessions end as does the first session with a summary of the goals and progress so far along with a suggestion of what clients might *do* and/or *observe for* in their lives that might be useful in maintaining and continuing their progress.

More detailed maps of first and later sessions as well as commentary on the maps are provided in several sources (see De Jong & Berg, 2013; de Shazer, 1988; Franklin & Kim, 2025; Lutz, 2014; McKergow, 2021; Ratner et al., 2012).

Number of Sessions

SFBT was not developed with the intention to be brief based on a specific number of sessions but rather to be a parsimonious and efficient therapy approach that could achieve effective results in as few sessions as determined by the client and therapist. The therapy might require one session or additional sessions, but it will be practiced efficiently to achieve effective change in as few sessions as possible. As de Shazer has been quoted as saying in his workshops, the correct number of sessions is "as long as it takes and not one session more" (Ratner et al., 2012, p. 29). However, as the approach developed in the 1980's towards one of co-constructing solutions with clients, the often time-consuming process of gathering problem assessment information became no longer necessary. Instead, the team at BFTC began solution development work with clients in the first session, asking for what was already happening in their lives that they wanted to continue to happen and gathering details about what a more satisfying life might look like. These first-session SF conversations coupled with having clients determine the length of their therapy likely contributed to SFBT becoming a brief therapeutic approach. An early study by Kiser (1988; also described in de Shazer, 1991, pp. 161-162) reports an average number of sessions of 4.6. A later study at BFTC in 1992 to 1993 using the same methodology reports the average number of sessions there continued to lower to an average of 2.9 (De Jong & Hopwood, 1996). Similarly, the large BRIEF practice in London, UK, has reported an average of fewer than 4 sessions (Ratner et al., 2012). The lengthy list of SFBT studies tracked by UK psychiatrist Alaisdair Macdonald over more than two decades suggests an average number of sessions ranging between 4 and 6 sessions (for a listing of these studies, see the website of SFBTA (https://www.sfbta.org). A recent systematic review of 256 outcome studies confirms these earlier studies showing that the average number of sessions for SFBT is 5.66 (Neipp & Beyebach, 2022).

NATURE OF THE CLIENT-THERAPIST RELATIONSHIP

As SFBT was developing in the early 1980s, the team at BFTC dramatically declared the "death of client resistance" (de Shazer, 1984). Instead of locating any lack of client progress in the broader field's commonly used notion of clients resisting the best efforts of the therapist, the team at BFTC redefined apparent client resistance as the therapist and treatment team not yet having found a way to *cooperate* with the client(s) (de Shazer, 1984; Korman et al., 2020). Since then, the hallmark of the client-therapist relationship in SFBT has been a collaborative approach. The therapist strives towards building a cooperative relationship with their clients through the co-construction of what clients want different in their lives and identifying related past successes that clients can use to realize their preferred futures. As the co-constructive sequences around these matters proceed in SF sessions and the clients and therapist work together toward the same direction—a

direction based on clients' wishes and priorities—client hope, motivation, and cooperation naturally develop. Dialogue #1 is a good example of how a SF therapist begins building cooperation from the beginning of the first session. In utterance #1 of that sequence, the therapist asks what would have to be different after their session for the client to say their meeting was somehow useful to the client. Through careful listening to what the client might want, the therapist is able to summarize in the client's words at utterance #25 that she is looking for "help" to "sort something out to get [her] life back together." He then invites her to build on her beginning notion of what she wants by asking for an indication that she is "getting her life together" to which she responds with "relaxing maybe." Throughout the therapeutic process, SF clinicians maintain this co-constructive posture, consistently working with clients to co-construct goals and identify related successes throughout all their sessions.

KEY PRACTICES

Solution-Focused Listening

The prior section "Listen, Select, and Build" describes how SF clinicians listen for and select the words and phrases from the client's language that are indications (initially, often only small hints) of some aspect of a solution, such as what and who are important to the client, what they might want, related successes, and client skills and resources. Berg liked to refer to this process as "listening with solution-focused ears" (De Jong & Berg, 2013, p. 21). Dialogue #1 and, indeed, all the dialogues that offered in this manual are examples of this way of listening to clients.

More recently, two sources have extended our understanding of this process and provided several examples of their particular way of conducting SF listening. Taylor and Simon (2014; Simon & Taylor, 2024) proposed that SFBT therapists think of each client utterance as offering multiple "opportunities" for SF responses by the therapist. Using a format inspired by microanalysis, these authors demonstrate ways to recognize such opportunities, to construct multiple possibilities for therapist responses, and to choose preferred responses as well as the rationales for preferred responses. A second source, Moon (2020) describes her use of a tool, also inspired by microanalysis, called the "Dialogic Orientation Quadrant" to teach new learners from the earliest moments of their training to listen in SF ways. More experienced clinicians, too, can use the quadrant to parse out each part of each client utterance according to the dimensions of future/past and positive/negative. Cross classifying these dimensions leads to the fourfold classification: client talk about the client's a) preferred future, b) troubled past, c) resourceful past, or d) dreaded future. The quadrant aids clinicians to make decisions about their next question or formulation as they move utterance by utterance through a session.

Solution-Focused Posture

The fundamental posture of SF therapists toward clients is one of not-knowing. Not-knowing is implicit in SF listening with the clinicians continuously listening for and selecting the clients' language and key words for what the clients want and related successes. As Anderson and Goolishian (1992) wrote:

> The not-knowing position entails a general attitude or stance in which the therapist's actions communicate an abundant, genuine curiosity. That is, the therapist's actions and attitudes express a need to know more about what has been said, rather than convey preconceived opinions and expectations about the client, the problem, or what must be changed. The therapist, therefore, positions himself or herself in such a way as always to be in a state of 'being informed' by the client. (p. 29)

This positive, respectful, collegial posture characteristic of SFBT is often referred to as "making the client the expert."

Beginning in a Solution-Focused Way

As the earlier quotation from de Shazer indicated, SFBT is organized around what clients want different in their lives, i.e., their goals. From the beginning of any first session with clients, the focus is on the mind of the clinician. In Dialogue #1, the therapist immediately starts the first session with his client with a goal-focused question:

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

The BRIEF practice in London, UK, begins first sessions similarly with clients. The BRIEF clinicians are well known for asking clients within the first five minutes of the first session: "So what are your best hopes from our talking together?" (Ratner et al., 2012, p. 63). Thereafter, the therapist commences the co-construction towards the clients' goals or preferred future.

An alternative beginning, following Berg's approach is beginning first sessions with a brief co-constructive sequence around client competency. Doing so establishes early on that the SFBT clinicians presuppose that the clients have competencies and are interested in hearing details about these and complimenting them. In the following dialogue, the therapist, who is seeing clients at a university mental health clinic, follows this approach before asking an opening goal-focused question.

Dialogue #2

1 Client (C): [*hands intake sheet to therapist*]
2 Therapist (T): Thank you. [*shuffles papers*] So is it ok if I call you Emma?
3 C: Mm-hmm.
4 T: Okay. Please call me Eric. I'm real comfortable with that.
5 C: Okay.
6 T: And, let's see you are…what year? [*scans intake sheet*]
7 C: I'm a junior.
8 T: You're a junior here, so…have you gone all your college years at (this university)?
9 C: Mm-hmm. [*nods and smiles slightly*]
10 T: So, you've been here for a while?
11 C: Yes.
12 T: What are you…what are you studying?
13 C: Um, I'm studying Spanish education and bilingual education.
14 T: Okay. [*takes notes on paper*]
15 C: So, I'll be, um, doing my student teaching in one year in the spring of next year.
16 T: Okay, so you've got a lot of background in Spanish.
17 C: Yeah.
18 T: Are you pretty good in Spanish?
19 C: Eh, I can hold my own. [*chuckles*]
20 T: Oh…[*nods head slightly*]…so you can carry on a conversation in Spanish?
21 C: Yeah, yeah I've studied abroad and I'm going to Guatemala this summer, so, for…most of the summer.
22 T: Oh…where, where did you study abroad?
23 C: In Honduras.
24 T: Okay, and then did you…[*motions with hands*] live with a Spanish-speaking family at that time too?
25 C: [*nods*] Mm-hmm. Yeah, it was a really good experience, and uh, it really improved my Spanish a lot when I was there.
26 T: So, you almost need that sort of thing, do you, to be able to…be conversational in Spanish, to have…
27 C: [*overlapping*] I think so, yeah…
28 T: [*overlapping*]…that living experience with it?
29 C: Yeah. Because you can study the textbook, you know, for hours and hours on end, and not understand what it means until you hear it or you have to use it, and…
30 T: [*nodding*] What would, what would the uh, Spanish people say about, Spanish-speakers say about uh, your Spanish?
31 C: As far as how…how good it was?
32 T: Yeah, how competent it is.
33 C: That's a good question. I don't know. Um, my profs have told me that it's…that it's good. Um, I've taken proficiency exams, and I'm what they call advanced low, which is where they want you to be, at least, so I definitely have room for improvement, but…
34 T: Mm-hmm, but you're proficient.
35 C: Somewhat, yeah.
36 T: So, they, uh, understand you, and can carry on a conversation with them?
37 C: Mm-hmm. Yeah. The hardest part for me is, um, understanding them more, because they…um, I'm used to how professors speak. You know, they speak pretty clearly, um, and a little bit slower, and I'm used to the words that they use. And then when you're with, you know, someone who is, um, not really in the academic setting, you know they use different words and they speak a lot faster and they slur things together, and, so, it's kind of like, "Oh, can you slow down a little bit?" So…

38 T: [*chuckles*] That's a lot of work.
39 C: Yeah, that's the hardest part for me, is like auditory kind of stuff.
40 T: Ahh, so you work a lot on improving your ear [*gestures to ear*] so you can…you can pick it up.
41 C: Yeah, mm-hmm.
42 T: Okay, well you have a…an ambitious professional goal.
43 C: Yeah, guess so. It's kind of a…oh I don't know how to describe it. Kind of like a hot [*draws quotation marks with her fingers*], you know, new thing that a lot of Spanish teachers are needed and English as a second language teachers, so…
44 T: Yeah, I'd say that's a…a huge need. A lot more mixing of peoples and languages.
45 C: Mm-hmm.
46 T: [*asking an opening question to a goal formulation sequence*] Okay, let's switch gears a little bit, Emma, and ask you, um, what would have to be different by the end of our conversation today, which (motions to clock on wall) you know, will be in about 45 minutes. What would have to be different for you to say that it was useful to come here and to talk to me?
47 C: Hmm. [*ponders, sits forward with hand on her chin*] That's a good question…

A critical consideration in getting started with clients is knowing ahead of time how they came to therapy. That is, it is important to know whether clients chose to come or whether it was someone else's idea they come, i.e., they were influenced, pressured, or required to come against their wishes. Dialogues #1 and #2 are instances when it was the client's choice to come to therapy. In cases where it was not the client's choice, the SFBT therapist proceeds a bit differently but still maintains the same objective of building a cooperative relationship with the client focusing on what the client might want different. A later section in this manual about working with clients in involuntary situations addresses how SFBT therapists proceed when the clients were referred by another party to therapy.

When SFBT therapists ask their first goal-focused question as the therapist did in Dialogue #1, clients customarily reply with descriptions of the problems they are facing. The therapist's responses are an illustration of how to invite the client to create constructions in a SF direction. There are several sources which present a variety of such dialogues that illustrate how to begin with clients in a SF way (see Berg & Miller, 1992; De Jong & Berg, 2013; de Shazer et al., 2007; Franklin & Kim, 2025; McKergow, 2021; Ratner et al., 2012).

Co-Constructing the Miracle or Preferred Future

The miracle question sequence invites a detailed, client-generated description of *what will be different* when what they want is happening more often in their lives. Experience at BFTC quickly taught the team that clients who constructed clear, detailed miracle pictures, also called "well-formed goals" at BFTC, were more motivated to change and made more progress over fewer sessions.

The miracle question was first used at BFTC in the early 1980s. In fact, it was invented from the interaction between a client and Berg (De Jong & Berg, 2013). Berg was interviewing a woman with multiple concerns about her children's behavior, her husband's alcohol use, and job difficulties. Early on in their first session, Berg asked the woman what would need to happen in her life for her to say her talking with Berg was useful. The

woman responded that she was not sure and that she had so many "problems." She then added, "Maybe only a miracle will help, but I suppose that is too much to expect." Berg, already in the practice of connecting to the client's words for what they might want, responded, "Okay, suppose a miracle happened, and the problem that brought you here is solved. What would be different about your life?" (De Jong & Berg, 2013, p. 91). To Berg's surprise, the woman who had seemed so overwhelmed began to describe an alternative future with her children thrived in school and she and her husband communicate better like they had earlier in their marriage. As she described this alternative future and Berg asked for more details, the woman became more hopeful. Soon, the clinicians at BFTC were regularly asking the miracle question as a way to amplify the description what clients wanted different.

Clinicians today continue to ask the miracle question or variations of it as part of SFBT. According to de Shazer (1988), the BFTC pioneers asked it as follows and emphasized it is best asked deliberately and dramatically:

> Now, I want to ask you a strange question. Suppose that while you are sleeping tonight and the entire house is quiet, a miracle happens. The *miracle* is that *the problem which brought you here is solved*. However, because you are sleeping, you don't know that *the miracle has happened*. So, when you wake up tomorrow morning, *what will be different* that will tell you that a miracle has happened and the problem which brought you here is solved? (p. 5)

The miracle question is the opening question to a co-constructive sequence in which SF clinicians connect repeatedly to the clients' words for what they might want different. Customarily, clients pepper their descriptions for what they might want with their difficulties or what they do not want. Skilled SF clinicians listen for and punctuate the clients' language for what they say they want by responding with formulations and follow up questions that continue inviting clients to construct or create descriptions of their preferred futures. Following is an example of how a couple, both former drug dealers with several years of previous contact with therapists and social workers, who said they wanted "social services out of our lives," began to respond to the miracle question.

Dialogue #3

1 Therapist (T): [*finishing the miracle question with …*] So, when you wake up tomorrow morning, what will be the first small clue to you… "whoa, something is different."
2 Dad: You mean everything's gone: the kids…everything?
3 Mom: No, no.
4 T: The problem is gone.
5 Dad: It never happened?
6 Mom: The problem happened but it's all better.
7 T: It's all handled now.
8 Mom: To tell you the truth, I probably don't know how…we're waiting. I mean, we're waiting on that day. We're waiting on that day when there is just nobody.

9 T: Nobody. No social service in your life.
10 Mom: Yeah.
11 T: How would you, when you sort of come out of sleep in the morning, and you look around and see, what will let you know... "wow, today is different, a different day today, something is different, something happened."
12 Dad: The gut feeling. The inside feeling. The monkey off the back so to speak.
13 T: Okay.
14 Dad: When I had a drug problem..., I guess it's a lot of the time the same feeling. When I had a drug problem I always was searching, and just always something, I never felt good about it. You know.
15 T: [*connecting to client words and meanings, ignoring the problem language and choosing one part of the client's message that is connected with what they want to feel differently*] So, after this miracle tonight, when the miracle happens, the problems are all solved, what would be different in your gut feeling?
16 Dad: Maybe I'd feel a little lighter, a little easier to move... not having to, ah, answer for my every movement.
17 Mom: Uh huh. Being able to make decisions as husband and wife. As parents of kids. Without having to wonder, "did we make the right decision or are we going to be judged on that decision?"
18 T: Oh.
19 Mom: I mean, this is what we feel is best, but when we have to answer our decision to somebody else …
20 Dad: Yeah, I mean "try it this way," or "try it that way," well, I mean, it's natural to learn a lot of those things on your own, I mean... I mean, you fail and you get back up and you try it another way.
21 T: So, you would like to make the decision just the two of you, you were saying, "hmm, this makes sense, let's do it this way" without worrying: "is someone going to look over our shoulder or not."
22 Mom & Dad: [*overlapping*] Right.
23 Mom: And whether we agree or whether we disagree. To have somebody, have somebody taking sides, you know, what is his point, what is my point, and then trying to explain to us, well...
24 Dad: [*referring to social services*] It was always having a mediator, I mean, ...
25 Mom: Yeah, there's always somebody to mediate.
26 T: So, the mediator will be gone. Will be out of your life.
27 Mom & Dad: [*overlapping*] Right.
28 T: [*connecting again to the clients' words and meanings, and then inviting more description of their preferred future*] O.K. All right. All right. So, suppose, suppose all these mediators are out of your life, including me. What would be different between the two of you? [*therapist stays silent while clients reflect and imagine*]
29 Dad: [*sighs*]
30 Mom: Everything. Like I said, being able to look at each other as husband and wife and know that if we have, if we agree on something, that that is our decision, and that's the way it's going to be. If we disagree on something, it's a decision that, I mean, that's something we have to work out between us, and we don't have to worry what that third person's opinion is going to be, and I don't have to have a third person saying, "Yes, well, I agree, the way Keith decided it was right." Which makes me feel even more belittled.
31 T: All right. So, you two will make decisions regarding your family. What to do about the kids, what to do about the money, going to do whatever, right?
32 Mom: Right.
33 T: Suppose you were able to do that without second guessing. What would be different between the two of you...that will let you know, "Wow! This is different! We are making our own decisions."
34 Mom: A lot of tension gone, I think.…

Provided is barely one-half of the MQ dialogue with the couple. The therapist goes on to gather more descriptions of what will be different in their relationship supposing the miracle happens. The parents speak of tensions in their relationship and challenges to the family, and the therapist, in response, keeps inviting them to describe what will be there *instead* when the miracle happens. They respond with "hugging each other," the mother feeling she is a good mother, the parents being "calmer" and "more relaxed," and so forth.

As with all SF co-constructive sequences, the miracle question sequence is a purposeful interaction. The SF therapist has several ideas in mind of what constitutes a *well-described* miracle picture or preferred future. Practice experience since the 1980s has informed that a useful miracle picture is concrete, observable, and situationally specific is important to the client. The three characteristics of a well-described miracle picture include: 1) the presence of desirable behaviors versus the absence of problems; 2) a beginning step versus a final result; and 3) a realistic description of what others will notice as well as what the client will notice (in their interactional consequences). These characteristics of a clearly developed miracle picture and the ways in which therapists can promote their construction by the client are described and illustrated in several sources (Berg & Miller, 1992; De Jong & Berg, 2013; de Shazer, et al., 2007; Franklin & Kim, 2025; McKergow, 2021; Ratner et al., 2012).

Co-Constructing Exceptions

Exceptions, also called past successes, are times in clients' lives when the problems or difficulties they present in therapy did not occur or were less severe (de Shazer, 1985). While clients often are not alert to exceptions, SF therapists listen for hints of them and facilitate co-constructive sequences around them. Doing so can instills more hope and motivation for positive changes in clients. The following dialogue is an example of the identification of exceptions between a mother and her daughter.

Dialogue #4

1 Mother (M): She [*referring to her daughter*] always just ignores me, acts like I'm not there, comes home from school, just runs into her room. Who knows what she is doing in there.
2 Daughter (D): You say we fight all the time, so I just go in my room so we don't fight.
3 M: See? She admits she just tries to avoid me. I don't know why she can't just come home and talk to me a little about school or something, like she used to.
4 Therapist (T): Wait a second, when did she "used to"? Anita, when did you use to come home and tell your mom about school?
5 D: I did that a lot, last semester I did.
6 T: Can you give me an example of the last time you did that?
7 M: I can tell you; it was last week actually. She was all excited about her science project getting chosen.
8 T: Tell me more, what day was that…?
9 M: I think last Wednesday.
10 T: And she came home…
11 M: She came home all excited.
12 T: What were you doing?

13 M: I think the usual, I was getting dinner ready. And she came in all excited, and I asked her what was up, and she told me her science project was chosen for the display at school.
14 T: Wow, that is quite an honor.
15 M: It is.
16 T: So, then what happened?
17 M: Well, we talked about it, she told me all about it.
18 T: Anita, do you remember this?
19 D: Sure, it was only last week. I was pretty happy.
20 T: And would you say that this was a nice talk, a nice talk between you two?
21 D: Sure. That's what I mean; I don't always go in my room.
22 T: Was there anything different about that time, last week, that made it easier to talk to each other?
23 M: Well, she was excited.
24 D: My mom listened, wasn't doing anything else.
25 T: Wow, this is a great example. Thank you. Let me ask this: if it were like that more often, where Anita talked to you about things that were interesting and important to her, and where Mom, you listened to her completely without doing other things, is that what you two mean by "better communication" [*a part of their miracle picture jointly developed earlier in the interview*]?
26 D: Yeah, exactly.
27 M: Yes.

In this example, the therapist first skillfully listened for an exception to the problem. Secondly, she punctuated that exception by repeating it, emphasizing it, gathering more details about it, and congratulating the clients on it. Thirdly, she connected the exception to their miracle picture (or goal) by asking the question, "If it were like that more often, where Anita talked to you about things that were interesting and important to her, and where Mom, you listened to her completely without doing other things, is that what you two mean by 'better communication'?"

Exceptions amount to clients' past successes. As Dialogue #4 suggests, especially useful exceptions for building solutions are those directly related to what clients want different in their lives.

Scaling Questions

Scaling questions are an interviewing tool that SF clinicians use to help clients express complex and intuitive impressions about past successes and future possibilities. These questions help clients evaluate where they are in relationship to their goal and envision further details and steps toward their preferred future. There are many types of scaling questions, all of which involve asking clients to rate something regarding themselves or their situations on a scale from 0 to 10. The clinician defines the poles, the 0 being the negative or lower end of the scale and the 10 the positive or more desirable end. It is common after doing the miracle question sequence to ask the clients to rate where they are on a scale where 0 equals when their problem (or situation) was at its worst and 10 equals the miracle they have just described. In the following dialogue, the therapist in Dialogue #3 asked this question of the family "who wanted social services out of their lives":

Dialogue #5

1 Therapist (T): Let's say, on a scale of one to ten, [*using her note pad to demonstrate a scale from low to high*], this stands for one [*bottom of note pad*], this stands for ten [*top of pad*]. And one was when your family was having a hell day, one of those hell days, can you imagine? That was for one. And the ten stands for this miracle [*see Dialogue #3*], tomorrow...actually happens...about. How close are you to the ten right now?
2 Dad (D): I think we're over the hump.
3 Mom (M): Yeah, six or seven.
4 T: Six or seven.
5 M: Yeah.
6 T: [*confirming with Dad*] Six or seven, do you agree with that?
7 D: Uh huh. I mean a lot has changed in the past year, I mean, we went from being to a point where we weren't really sure just what was happening, what was gonna happen, or where we we're going to be today...right now. Maybe in the last two or three months we've come a long way…
8 T: You said you were over the hump.
9 M: Um hmm.
10 T: What tells you that?
11 D: That we're able to see the future a little bit. Able to make plans. Um.
12 M: We know, I mean—
13 D: [*overlapping*] We have certain goals set.
14 T: Wow.
15 D: Granted, I've always had long term goals set. But they've [*social services*] always been-
16 M: Just-
17 D: [*referring to social services*] putting us back.
18 M: And the kids—
19 D: [*overlapping*] —more or less [*still referring to social services "putting us back"*]
20 M: [*returning to what tells her the family is a 6 or 7 on the miracle scale*]…The way they [*the children*] play with each other, the way they hug each other, and the way that they sit they sit with each other, and they grow up. To know that they've learned that no matter how much they hurt each other, that I know that, like Mike [*the oldest boy in the family*] right there a while ago, he would have never let, would have never had anything to do with her [*his sister*]; to where you know that their relationships, brother and sister have become more treasured to each other. So, when they fight it's not as serious…
21 T: Okay. So, those moments like when they calm down, when you calm down, and when you feel like: "Phew! I can see them playing together." That's what makes you think: "We are over the hump."
22 M: We're getting there. And when—
23 T: [*overlapping*] You are getting there…[*to Dad*] What, what about you? What tells you that you're over the hump?
24 D: [*Silence*] I think, um, the financial end of it. Um, a lot of the emotional trauma we've been through, we've, we never really talked much about it as a family, as a whole. But I think…we know we can bring it up now and not feel real...you're always gonna feel bad about it…you'll still be able to sleep at night. You know? So—
25 T: So, you see some hope at the…you see a light at the end of the tunnel.
26 D: The light at the end of the tunnel. Yeah.

de Shazer et al. (2007) referred to this scaling question as the "miracle scale," which is useful for several reasons. Firstly, the question requests that the client to assign a number or estimation of something about themselves or their situation. In the example above, the mother and father agreed that their *progress* so far, relative to their goal of getting social

services out of their lives, is at a 6 or 7, or, as the father put it: “I think we’re over the hump.” The therapist then asked the parents to expand on their self-assessment: “What tells you that you are over the hump?” Clients regularly respond to this follow up question by citing exceptions or past successes related to their miracle picture. Here, the parents mentioned, among other things, that they are able to see the future, make plans, their children are now playing with and hugging each other in reassuring ways, and the parents are more able to talk about the financial aspects of improving their situation. Once clients identify such successes, the therapist can continue with follow-up questions for the details of these successes as well as what the clients did to make them happen.

There are several other applications of scaling questions. For example, therapists can ask clients how motivated they are (or how hard they are willing to work) on a scale from 0 (no motivation) to 10 (I would do almost anything) to improve their situations. Therapists can also ask their clients to scale their level of confidence in improving or solving their problems (0 = no confidence and 10 = every confidence). Clients often initially assign numbers between 1 and 4 in response to these questions. Therapists then explore clients’ thinking around the numbers. For example, therapists might ask, “What tells you that you are at a 3 level of confidence of finding a solution?” or “Where does that confidence come from?” As clients construct their answers to these questions, they are revealing to themselves and their therapists the strengths and resources they believe they can bring to bear on creating the more satisfying lives they want. Because scaling is a basic part of SF practice, there are several sources that extensively discuss how scaling is used in SF practice and offer examples of SF scaling dialogues (Berg & de Shazer, 1993; Berg & Miller, 1992; De Jong & Berg, 2013; de Shazer et al., 2007; Franklin & Kim, 2025; McKergow, 2021; Ratner et al., 2012).

Relationship Questions

The SF questions in the dialogues presented so far in this manual ask clients to answer from their own points of view, e.g., the client’s best hopes, what the client might want, the client’s levels of progress, motivation, and confidence. However, as social psychologist George Herbert Mead (1934) pointed out, peoples’ views of themselves and their situations are not solely individually formed; people also see themselves and their situations as they perceive other important people in their lives view them. This important influence of significant others and social contexts on clients is captured in SFBT through the use of relationship questions (Berg & de Shazer, 1993). For example, in the context of asking a client the miracle question, the therapist will also ask: “Who knows you well?” The client might say: “My best friend.” The therapist then will ask the client to add to the developing miracle picture by asking a relationship follow-up question: “So, when the miracle we have been talking about happens, what will your best friend notice that’s different about you?” The client might answer: “I’ll be happier and more relaxed.” Then, the therapist might continue with: “And when your best friend notices you being ‘happier and more relaxed,’ what will be different between the two of you?” Using relationship questions this way invites clients to expand their own viewpoints by looking at themselves and their situations through the eyes of their significant others. It also invites them to build

miracle pictures and eventual solutions that are interactionally aware and, hence, likely to be more useful. Relationship questions, then, are a conversational tool that allow therapists to easily bring the clients' social context into the SFBT conversation, making them especially useful, even essential, in work with clients who have not self-selected to be in therapy. We address and illustrate the application of relationship questions in working with mandated clients in a later section.

As with the other key practices briefly presented in this manual, relationship questions are discussed and illustrated at length in several sources (Berg & Miller, 1992; De Jong & Berg, 2013; de Shazer et al., 2007; Franklin & Kim, 2025; McKergow, 2021; Ratner et al., 2012).

Co-Constructing "What's Better?" in Later Sessions

All later sessions in SFBT begin the same way with therapists asking clients what has been better since they last talked. This question is a form of an exception question intended to identify clients' recent successes. Berg suggested SF clinicians practice "EARS" when asking about "What's better?" (De Jong & Berg, 2013, pp. 149-156; Gingerich et al., 1988). EARS is an acronym describing the co-constructive sequence with clients around what's better. "E" stands for *eliciting* the exception; "A" for *amplifying* the exception by describing the details of the "who, what, when, and where"; "R" for *reinforcing* the successes and strengths co-constructed around the exception; and "S" for the therapist to *start again* by asking: "What else is better?" As an illustration, the following is the beginning of the second, i.e., a later, session with Emma, the university student and same client from Dialogue #2. After that opening sequence in her first session, Emma went on to state that she was struggling with "feeling very emotional" when her best friend and roommate's boyfriend came to their apartment with increased tearfulness and difficulty sleeping. During the miracle question sequence, she identified several potential changes: she might be less likely to leave when her roommate's boyfriend visits, more capable of feeling happy that her roommate has found a boyfriend she enjoys, experience more calmness, and sleep better. Because her miracle picture was clear and detailed, the therapist suggested she pick one day in the next week and "pretend the miracle"—to live that day as though the miracle has happened. Emma returned for the second session a week later.

Dialogue #6

1 Therapist (T): [*eliciting*] So, tell me, what's—what's going better?
2 Client (C): Most things are going better. Um…
3 T: [*impressed*] Yeah?
4 C: Yes, it's, this week has been really good, and, but um, uh, well it's [*the weather*] nice out, therefore I've been running, um, so I worked out 4 times this week already, and so that has caused me to be quite a bit more tired when I go to bed, and so I'm sleeping much better.
5 T: [*eliciting and inviting C to amplify*] So that's one thing that's better, is that you're sleeping better.
6 C: Yes. I'm falling asleep much quicker, um, I haven't had a night yet this week that has been frustrating, um-
7 T: [*again impressed*] Really!
8 C: Yeah.

9 T: [*reaching out to shake her hand; client is surprised but shakes his hand and chuckles*; *reinforcing*] Congratulations!
10 C: I know!
11 T: Oh, that's wonderful.
12 C: So, yeah! So, it seems that my working out more is helped me quite a bit.
13 T: Mm, that's what you think is, is doing it?
14 C: That's part of it, I think. Um, the other part just being that, well I sort of had in my mind like my, my miracle day was Wednesday, uh, you asked me to pick a day.
15 T: Ah, okay.
16 C: And uh, but of course all the days leading up until Wednesday I was kind of thinking about that day and how that was gonna be, so it kind of ended up being like most of my other days I was kind of in that mindset also, and—
17 T: Uh-huh, you mean the, the miracle mindset.
18 C: Right, um.
19 T: Oh, okay.
20 C: And so, I just felt very, um, assured every day that, you know I was a good person and it was ok to, you know, be like by myself or whatever, and uh, [*speaking softly*] yeah, I just felt confident this week and not—
21 T: Did you say confident or competent?
22 C: Confident.
23 T: You felt confident, okay.
24 C: Mm-hmm, and uh, and I've had very little anxiety when I you know, go to bed and everything, and if I do start to feel you know anxious or whatever, I just kind of am more aware that, that that's something I can have control over, that I can like, kind of shut those thoughts down and just not give in to that, and I haven't cried this week either, not even one time.
25 T: [*with admiration*] Really!
26 C: So, yeah, it's been pretty amazing how quick the turnaround was.
27 T: Yeah, that's very quick. Very quick!
28 C: Yeah.
29 T: [*amplifying*] Wow. Is this new for you? That—, you were talking about when you have the anxiety, that now you feel like you can have control over it and you can, and you can shut it down? Is that something that's new for you or is that something that you've always been able to do?
30 C: Um, I feel like it's pretty new, because before, like I said, you know, last time, if my best friend's boyfriend would come over that was kind of like, kind of like a dark cloud for me, and it was just like he almost dictated how I was feeling. I mean, he didn't, he didn't, wasn't at fault at all, it was my issue, but like if he would come over, then I felt like this is how I have to be feeling, because that's how he makes me feel when he comes over, and, but this week I was just like, well, I don't have to feel that way. I can choose not to feel that way, and we actually had very positive interactions this week—
31 T: [*inviting more amplifying*] You and he have?
32 C: Right. Um, and I just made a very conscious effort to, do the things that I said I was going to do on my miracle day that when you asked me what, you know, my best friend would notice different about me, and you know one of the things I said was that I would ask her, you know, how her time was with Allen, and, you know, what they did and be genuine about it and want to know, and be glad that they had spent time together and that they enjoyed their time together. And so, in doing that I found that I was being genuine about it, you know that-
33 T: Did that part surprise you? That you could ask and be genuine about it?
34 C: Yes! Yeah, um
35 T: Wow, great discovery!…So, that's, that's quite a change, that's a remarkable change!
36 C: Yeah.

37 T: Mm-hmm. [*using relationship question to invite amplifying*] So what, if Allen were here, and I were to ask him how you were different with him this week versus previously, what do you suppose he would say?

38 C: Um, I'm not sure if he would recognize anything, because like I said before I'm pretty good at like pretending to be happy around him, um, but maybe I'm not as good of an actor as I think I am, [*chuckles*] I don't know.

39 T: So, what might he have noticed different if he were very perceptive and picked it up?

40 C: Um, that I was definitely willing to share my time with, with him and with my best friend, and um, that…I don't know, he might just kind of sense from the way that I talk to her or talk to him that I was you know glad he was over and um, actually, he was looking for an anniversary gift for my best friend online and he sent me a couple pictures, and so I got, I got to give him some input on you know what gift to get her, um, and so our relationship was very constructive, we were really kinda helping each other out this week. I was really willing to help him and was excited about it, so he probably noticed that.

41 T: [*reinforcing*] So, he could see that, he really could see that, okay.

42 C: Yeah, mm-hmm.

43 T: How about your best friend? What do you suppose she might have noticed? [*pause*] That was different about you…

44 C: I didn't cry. She didn't have to comfort me this week. That was another thing that I think was, um, that just by kind of admitting out loud that part of the reason that I was upset a lot is because I knew that was how I could get her attention, um, and this week I didn't feel like, like that was something I needed to do, that I could get her attention in better ways than that.

45 T: Mm-hmm. And you, and how did you do that?

46 C: Get her attention in better ways?

47 T: Yeah.

48 C: Um, just talk to her about normal things and not feel like, I mean I, I know that she pays attention to me when I'm happy but I just, for some reason, that like wasn't enough for me in the past few months. Um, I was also pretty busy this week, so that also helped that, you know I wasn't spending any time just kind of sitting around and waiting for her, like her to come home, or her to you know hang out with me or whatever, I just was busy and had my own life and, um, so the time that I did spend with her was very constructive, cause we were, you know, excited to be able to hang out because we didn't see each other a lot, so, mm-hmm. Yeah, I can't believe I went for a whole week without crying, it's pretty amazing. [*laughs*]

49 T: [*amplifying*] Now that you've done all this, what do you imagine is different between you and your best friend? Even a little bit different?

50 C: I feel like before she was caught in the middle of me and her boyfriend, that she was trying to please both of us and she couldn't really do it at the same time because if she was pleasing me, she wasn't pleasing him and vice versa. Um, because he, he and I have pretty similar personalities. We're kind of needy people at times. Um, and he, like I told you before, feels threatened sometimes when she hangs out with me instead of hanging out with him, she chooses to hang out with me instead, and um, so I felt like…that that kind of changed, that I'm like more on her side, and I'm on his side, and like willing to, just kind of work together, and um, I don't feel like I'm manipulating her at all, um, and she's had some struggles this week, so it's almost like we've reversed roles in some ways. Um, cause she…is very emotionally stable. She rarely gets upset, but she was very upset last night, and so I was able to, because I was in a good state, I was able to help her, um…

51 T: [*amplifying*] What did you do that was helpful for her?

52 C: Um, I just kind of sat there and rubbed her back and listened to her, cause she, you know she was crying and just kind of explaining what you know she was upset about, and I was like well, you know what can we do to, to um, make you a little happier for the rest of the night, you know? I mean we can sit here and cry and whatever but I know that's not really what you want to do, because she hates crying, so, doesn't like doing that, so…she's like, "Well, we could you know go get some ice cream," I was like yeah we can do that, so we went to the store and um then watched one of our favorite TV shows, and uh, yeah, so I felt like, it was really nice to be in that role because I've been in the opposite role so much lately, that I feel like oh, you know I'm not just some little cry-baby, that other people need, need me too and I need to be, I need to be like ready to help them and not so focused on myself, and um…yeah.

After about 30 minutes of doing EARS with the client, the therapist asked the client to scale her progress with 0 being where she was at when she decided to come for therapy and 10 being the miracle she had described. She stated she was at an "8." After asking more about how she made the 8 happen, the therapist asked her to scale how confident she was she in remaining at an 8 or even go higher. She gave a "7 or 8" to her level of confidence. The therapist then asked her what would be different were she to go up to a 9, that is, what would be happening were she to move up to a 9. This question invited her to continue constructing her preferred future, building upon the significant progress she had already achieved. The therapist then summarized Emma's successes over the past week and suggested she continue to do more of the same and continue paying attention to what else she might have done to make her miracle happen that she had not yet noticed. That ending message is provided in a later section of this manual.

Pre-Session Change

de Shazer and the team at BFTC came to recognize that they did not have to initiate positive client change but rather that change was always occurring in clients' lives. All the team had to do was ask about the change by assigning the FFST and at the following session asking what was better or for exceptions. In the process, the team naturally stopped asking about problem details in first sessions and began solution development questioning early in their first interviews with clients (de Shazer, 1988). One of the ways of engaging the naturally occurring, positive client change was to ask directly about "pre-session change" (Weiner-Davis et al., 1987). As Weiner-Davis et al. (1987) describe the process, the therapist informs the client that often people notice changes between when they scheduled the appointment for therapy and the first session. The therapist then asks, "Have you noticed any differences, too?" If the client says yes, the therapist asks if the changes relate to the reason(s) the client came for therapy. If the client says yes, the therapist asks if these are the sorts of changes the client would like to see continue. And if the client says yes again, the therapist immediately moves to a co-constructive sequence of EARS around the positive changes the client identifies. Early research by Weiner-Davis and her BFTC colleagues indicated two-thirds of clients identified positive pre-session change (1987, p. 360).

Coping Conversations

Some clients seek therapy in response to recently experienced crisis, significant loss, or otherwise overwhelming circumstances that leave them feeling incompetent in managing the challenges in their lives. They may have been assaulted, attempted suicide, lost someone very dear to them, received a diagnosis of a life-threatening illness, or endured a painful breakup or divorce—to name some reasons for seeking therapy. The challenge for therapists is determining how to respond effectively and solution building with someone focused on the details of what is so troubling and overwhelming to them. While empathizing with and acknowledging the client's loss of wellbeing, SF clinicians also recognize that, even in very difficult circumstances, clients are likely employing positive coping strategies, however small. Therapists can then invite clients to identify and build upon these existing strengths and ways of coping. A co-constructive sequence around coping often begins with the therapist asking some form of the question: "With all that's been going on in your life, what have you found that's been useful, even a little bit?" The client may respond with something like: "I try not to think about it,"; "I try to slow down my breathing"; "I try to calm down"; or "I call my mother," and so forth. Each of these may describe a small success, and the SF clinician sets about conducting an EARS sequence. Thereafter, they use scaling to measure the client's perceived progress on a scale where 0 equals "I'm not coping at all" and 10 equals "I'm coping as well as I can imagine anyone coping in this situation." Then, the clinician begins to explore what will be different when the client is coping at a level of one or two numbers higher. More detailed discussions and examples of coping dialogues are included in several sources (see De Jong & Berg, 2013; Fiske, 2008; Franklin & Kim, 2025; McKergow, 2021, Ratner et al., 2012; Simon, 2010).

Complimenting

Compliments are another integral part of SFBT since its inception. They were given in the first part of a session ending message to indicate what the therapist and team thought "the client is doing that is good for him or her" (de Shazer, 1985, p. 91). Soon, compliments were regularly being used throughout SFBT sessions, and different types of compliments were conceptualized. There are three types of compliments (Berg, 1994; Berg & De Jong, 2005; Thomas, 2016). First, there are "direct compliments" in which the clinician expresses admiration or formulates something positive about the client. In Dialogue #6 there are multiple examples of direct compliments (see utterances 3, 7, 9, 11, 27, 35 among others). Second, there are "indirect compliments," which are questions that contain presuppositions that imply something positive about the client. For an example, see Dialogue #6, utterances #37 and #39 when the therapist asks Emma what Allen (the roommate's boyfriend) might have noticed about "How you were different with him this week versus previously, what do you suppose he would say?" Of course, so many SF questions are essentially indirect compliments because they consistently carry positive presuppositions about clients. A third type of compliment is when the client uses a "self-compliment," which occurs when clients state something positive about themselves. Attentive SF clinicians recognize clients' self-compliments and reinforce them by inviting clients to amplify these positive self-observations through indirect compliments. Utterance #29 in Dialogue #6 is a good example of a SF therapist noticing the client's self-

compliment and following up with indirect compliments to invite the client to amplify her self-identified success.

Taking an Optional Break and Developing a Session-Ending Message

From the original development of SFBT in the 1980s until the passings of de Shazer in 2005 and Berg in 2007 and the subsequent closure of BFTC in 2007, therapists and the team at BFTC employed the technique of taking a break near the end of each session. This approach was used to formulate a message for their clients. The team and interviewing therapist consulted with one another, focusing on the client's stated desired outcome, the clarity of their miracle picture, related exceptions, and progress made thus far towards their goals. If a therapist was working independently, they would excuse themselves from the therapy room to self-consult on the aforementioned matters and develop the message before returning to the therapy room and delivering the message. The message itself included compliments that acknowledged what clients were are already doing to create progress toward what they want, affirmation of their goals, and usually, a suggestion. There are two types of suggestions: observational and behavioral. Both are based directly on the solution-building information co-constructed in the session and, therefore, fit the client's frame of reference. In an observational suggestion, the therapist suggests the client *look for* something in their life that is likely to be useful in promoting the progress the client wants. In a behavioral suggestion, the therapist suggests the client *do* something, usually something the client has already suggested would be useful to promote more of the progress they want. As an example, provided is the ending message the therapist gave to Emma at the end of their second session.

Dialogue #7

1 T: [*complimenting*] Okay, Emma, so I went back over all these things that you told me, and it really has been a remarkable week. You know it's almost like not just one day but the whole week was like the miracle picture you described to me last week, and what I'm so impressed about is you not only can describe so clearly what made it such a good week, but you can also describe to me so clearly the steps that you took to make it, to make it that way. So, I'm not surprised that you say that you're, you know, that you're at an 8. And, I'm also not surprised that you're in the 7 to 8 range on your confidence of, you know, of knowing what to do. You're so clear about the steps that you took…everything from the running [*jogging*] to thinking very clearly about what kind of person you wanted to be in relationship to other people, and then keeping that in front of you the whole week and being very intentional about doing those things. And, I think it's really to your credit that you not only thought it through but that you were able to do it. You know not everybody would've been able to do it, but you made it happen. [*pause*] And, I agree with you every week in the future may not be exactly like this week.

2 C: Yeah.

3 T: [*complimenting*] And that's to your credit, too, that you're realistic about that. I mean life is work, and there are going to be some weeks which are more work than other weeks are, [*implicitly affirming client's goals*] but clearly you have a sense of direction, so you just have to stay on that track, and, in addition [*behavioral suggestion*] to doing those things that you know are so useful to you, I would suggest that [*observational suggestion*] you keep paying attention to what else you're doing to make that miracle happen that you haven't already noticed. Ok?

4 C: Great.

Not all SF clinicians take a thinking break to develop an end-of-session message for clients. Instead, some prefer to integrate offering the compliment, the affirmation of the clients' stated goals, and suggestions, such as the observational and behavioral suggestions cited above, directly into the interview session (Ratner et al., 2012; McKergow, 2021). Regardless of whether the clinician chooses to take a break or incorporates feedback throughout the session, both approaches include the same key practices of complimenting, affirming what clients want, and making suggestions that fit with clients' solution building efforts so far.

Addressing When to End Therapy

Unless someone else, such as a parent or the court, has decided the length in which a client remains in therapy, the client is considered the expert in determining when to end therapy. For SFBT therapists, addressing therapy duration with clients is a fairly straightforward matter. In general, from the second or third session on, the topic can be incorporated with scaling progress. As explained above, later sessions involve a co-constructive sequence around what has been better in clients' lives since the last session, followed by scaling progress with 0 equal to where things were when they decided to come to therapy and 10 equal to their miracle picture or preferred future. After clients assign a number to their current level of progress, the therapist often asks: "What number do you need to be on that same scale not to have to come back and talk to me anymore?" If the client's progress and confidence are high enough to satisfy themselves (usually a 7 or 8), they commonly say they have what they need for the time being. Often clients will mention—or the therapist can remind them—that the door remains open for future sessions if needed, and for now, it is not necessary to schedule another session. Various iterations of this approach to concluding therapy is discussed and further illustrated in several SFBT sources (see De Jong & Berg, 2013; McKergow, 2021; Ratner et al., 2012).

PRACTICE CHALLENGES

SFBT is a particular way of conducting a therapeutic conversation. Consequently, the practice challenges that therapists face involve getting and staying on a solution-focused track with their clients. In this section, several such challenges are identified along with some of the ways in which SFBT clinicians respond to them.

Moving From "Problem Talk" to "Solution Talk"

When clients seek therapy, they do so because they are experiencing difficulties or problems they wish to change. It is natural then that when the therapist first asks, "What needs to happen or be different for you to say our talking has been useful?," clients will respond with descriptions of what is wrong in their lives. Within clients' problem descriptions are usually indications of solution talk about what clients care about, what they might want, and even exceptions or times when things are a bit better. Getting on a solution-focused track involves listening empathically and also selecting out the fragments

of solution talk to begin a co-constructive sequence around these fragments. Dialogue #1 is a good example of getting on a solution-focused track early in a first session. In addition, all the dialogues presented so far in this manual consistently illustrate that problem talk and solution talk are interwoven throughout all first and later sessions and serve as examples of how SF therapists can invite clients to move toward and amplify their solution talk.

While ongoing problem talk is not useful to solution development (Gingerich et al., 1988), some problem talk is a natural part of and useful in solution building. Clients regularly use their descriptions of problems as a contrast to their efforts to construct an ever more detail vision of what they want different in their lives as well as new and different ways of handling their challenges. In their microanalysis of co-constructive sequences, De Jong et al. (2024) found interviewees consistently described what they did poorly in their first attempt at a difficult task as a basis for describing what they would do differently and better the next time they faced the same task.

Responding to "I Don't Know" or Silence

SF questions are often ones that clients have seldom or never been asked. As such, it is common that therapists will first hear clients respond with "I don't know" or with silence. SF clinicians' best response in these situations is to assume that they have posed a challenging question, i.e., one that constructively challenges the clients, and to remain silent. Since clients have been asked a question, they understand it is their turn to speak next, so by remaining silent, therapists allow time for clients to think and construct a response. Most often, the client follows the "I don't know" response with a pause and then a beginning answer to the therapist's challenging question. Dialogue #1 exemplifies this common pattern of interaction in SF dialogues.

Getting Details

The co-constructive sequences in SF sessions are about gathering details around an opening question such as the "best hopes" question, "miracle question," "what's better," and so forth. In conducting these sequences, a therapist regularly encounters some predictable interviewing challenges. Described are three common challenges and ways SF clinicians commonly respond.

Moving from "Absence of…to Presence of…"

When clients are asked what they want different, they often begin by describing what is happening that they do not want. SF therapists then respond with some form of "What will be there instead when things are better or when the miracle happens?" In Dialogue #3, utterances #14-16 provide an example of this exchange. In utterance #14 of the miracle question sequence, the client states that when he had a substance use problem, he had ["a gut feeling"] of always searching and never feeling good about that. The therapist invites him to construct what will be there instead of the "searching" by asking: "So, after this miracle tonight, when the miracle happens, the problems are all solved, what would

be different in your gut feeling?" The client then defines what will be there instead: "I'd feel a little lighter, a little easier to move …" Across these three utterances, with the intentionally crafted follow-up question by the therapist, the client's developing definition of the miracle moves from the absence of the feeling of "always searching" in his gut to the presence of feeling "a little lighter and easier to move."

Moving From General to More Specific

Clients often respond to the opening or framing question in a co-constructive sequence with a general answer. Dialogue #1 offers an example, which begins with the therapist's question: "What will have to happen, as a result of you [gestures toward her] coming here today—this afternoon, tomorrow, the day after tomorrow—for you to feel that it's been somewhat useful to, to be here?" The client eventually is able to construct a beginning general answer which the therapist summarizes as: "Help you sort something out to get your life together." He then invites the client to begin to move from a description of something more general to something more specific by asking the follow-up question: "So, what would be a feeling, ah, a thought, an action, something you would do or think or feel that would tell you that you were sort of getting your life together?" The client responds by constructing something more specific: "relaxing, maybe."

Moving From the Non-Observable to the Observable

Clients' described preferred futures and successes, at least in part, in observable versus non-observable terms offer greater clarity. When described in observable terms, clients, therapists, and any third parties can more clearly identify the elements of the clients' preferred futures, i.e., goals, and determine whether clients' successes have indeed occurred. SF clinicians, therefore, as part of their co-constructive sequences, regularly invite clients to describe what they want and their successes in observable terms. There are several approaches, one of which is to use a relationship question. The therapist in Dialogue #6, in his "what's better" sequence with Emma, asks in utterance #39: "So, what might he [the roommate's boyfriend] have noticed different [about you that was different this week] if he were very perceptive and picked it up?" Emma respond includes: her willing to share more time with him and her roommate, speaking differently to both of them in a way that indicated that she (Emma) was glad he was at their apartment, and that she (Emma) offered him some input about what gift to give the roommate; her description of differences are observable behaviors. Relationship questions tend to generate client descriptions in observable terms because they ask clients to answer in terms of what another person might observe about them.

When "Nothing is Better"

Of course, not all clients start answering the "what's better" question in later sessions the way Emma did in Dialogue #6. Some clients respond to the question with ambivalence, stating they are usure if anything is better. In these cases, it is useful that the therapist ask the client whether particular days were even a bit better than others since the last session. When the client identifies one day as at least somewhat better than another, the therapist

has an opportunity to conduct a co-constructive sequence around what made that day better. In a few cases, clients will be resolute that "nothing is better," or even say that "things are worse." A SF clinician does not challenge these perceptions but accepts them. After acknowledging and empathizing with how difficult things have been since their last meeting, the therapist often goes on to ask some form of the following question: "As bad as things have been, if your best friend (or partner, or someone else that knows the client well) were here and I were to ask, 'What have you noticed _____ (the name of the client) doing to deal with the challenges they face right now?' What would your best friend say?" Often, the client can construct an answer that identifies a coping success that then becomes the starting point for a coping conversation using EARS—Elicit, Amplify, Reinforce, and Start Again.

Recurrences, such as a return to drinking or other substance use, are a form of the "nothing is better" or "things are worse" response. Clients who experience recurrence often feel discouraged, particularly after putting in significant effort to abstain from substance use or some other compulsive behavior. SF clinicians have long viewed recurrences differently than other clinicians; clinicians recognize that since the previous session with the client, there most likely have been days when the client used, used less, or did not use at all while the discouraged client may be focused solely on their recurrence (Berg & Miller, 1992). After acknowledging the client's discouragement, SF clinicians refocus through a SF co-constructive mindset on the days when the client used less or not at all.

When Clients Seem "Unrealistic"

Clients often say things that at first may strike the clinician as unrealistic. Sometimes, what clients say is virtually or, in fact, not possible. For example, in response to the miracle question, the client might say "I'd win the lottery," or a client who has lost a loved one might describe a scenario where that special person would still be alive. In such situations, SFBT clinicians pause and remain silent while providing nonverbal expressions of understanding and empathy, e.g., offering a sympathetic nod. The client often elaborates that they know that what they said is not going to happen and they continue in a more realistic direction. At other times, what clients say is not impossible but may not be as probable to occur based on what the client has discussed. For example, a client, Bill, who made a suicide attempt two days earlier when his partner unexpectedly left him, might say to the clinician that on a scale from 0 to 10 that there is "0 chance that he will attempt to take his life again." The clinician does not challenge the client's apparent perceptions but responds from a posture of curiosity, respect, and not-knowing. The clinician might ask: "Knowing yourself the way you do, what tells you there is '0 chance' of you doing it again?" The clinician might alternatively ask a relationship question: "Suppose your best friend were here and I were to ask him, on a scale from 0 to 10, what number would you give to the possibility that Bill might attempt to take his life again?" Both questions are opening prompts to co-constructive sequences that offer the client space to identify the inner and outer resources he can utilize to help him respond and adjust to the recent challenges in his life.

Conclusion

The above examples of challenges in practice have been discussed since SFBT was developed in the 1980s. These challenges are discussed in detail in several sources along with illustrative dialogues (see, for example, Berg & Miller, 1992; De Jong & Berg, 2013; de Shazer et al., 2007; Franklin & Kim, 2025; McKergow, 2021; Ratner et al., 2012).

TARGET POPULATIONS, SETTINGS, AND MODALITIES

SFBT encompasses a wide scope of practice; rather than being problem specific, it is a purposeful and useful conversation approach with clients. This framing enables SFBT to be used in any context that involves talking to clients about their goals and ways to achieve them. The modality was first developed in working with individuals, couples, and families with psychosocial problems in a clinical setting within an outpatient family therapy clinic where it first established its feasibility and effectiveness. As SFBT developed, it was increasingly practiced in group and organization settings. Sources that summarize the practice applications of SFBT include De Jong and Berg (2013), Franklin and Kim (2025), McKergow (2021), and Ratner et al. (2012).

SFBT has been successfully practiced with clients who experience several different types of psychosocial problems such as:

1. Internalizing symptoms (e.g., depression & anxiety) (Kim 2008; Schmit et al., 2016);
2. Externalizing symptoms (e.g., substance use & behavioral problems among youth) (Franklin & Hai, 2021; Hsu et al., 2021); and
3. Trauma symptoms (Eads & Lee, 2019).

SFBT is especially effective with depression (Gingerich & Peterson, 2013) and in early intervention with youth and families (Bond et al., 2013). Zak & Pekala (2024) discussed that across studies, SFBT demonstrated high confidence in its effects with depression and overall mental health outcomes with adults and moderate effects in internalizing disorders (e.g., depression & anxiety) with children and adolescents.

SFBT has been widely practiced with children and adolescents in schools, community settings, and outpatient mental health services (Ali et al., 2024; Franklin et al., 2022; Franklin et al., 2023; Neipp & Beyebach, 2022). It has also been used in social services, child welfare, and institutional settings such as residential programs and prisons (Kim et al., 2019; Stams et al., 2006). The practice of SFBT within healthcare and primary care settings has also been growing in recent years (Zhang et al., 2017; Cooper et al., 2024).

Studies have further shown that SFBT is effective when practiced with individual, couple, and family modalities and that the intervention especially works well when used in a group modality (Neipp & Beyebach, 2022; Vermeulen-Oskam et al., under review; Franklin et al., 2022).

SFBT is now regularly being used as a practice modality in the field of coaching throughout the world. As in the disciplines of psychotherapy, counseling, and social work, SF practices are used in coaching individuals, couples, task groups, and organizations. Several sources are now available describing solution-focused co-construction in coaching contexts (Berg & Szabo, 2005; Iveson et al., 2012; Moon, 2020).

Working With Clients in Involuntary Contexts

Many clients who attend therapy have not made the decision to seek services voluntarily; rather, they were influenced, pressured, or even legally required to do so. Most children and adolescents who attend therapy were referred by parents, caretakers, teachers, or other adults who believe they require services. In couples, it is often one partner's idea more than the other to seek therapy. Employers send under-performing or seemingly "troubled" employees for services. Courts mandate offenders and perceived neglectful or abusing parents and caretakers of children to see therapists. And the list goes on.

In problem-specific approaches to therapy, the clinician first engages clients through active listening and empathizing before moving on to problem assessment and a related problem-solving therapy. Often this approach is met with client resistance because clients do not share their clinician's views of their problems or situations, hence, are not motivated to make the changes their clinician believes is necessary.

As previously stated, a critical component in working in a SF way with involuntary clients is to know ahead of the session the reason they are attending therapy. Knowing this context allows the therapist to begin the therapeutic process by seeking understanding of the client's perception of their situation; what is important to them; what they might want given that situation; and the resources they might bring to build solutions for themselves in that context. The following dialogue illustrates this SFBT approach. Excerpts are taken from a first meeting between a foster care worker and a client whose sons were recently removed from his care for alleged abuse. The first excerpt is from a conversation on the client's front porch when the foster care worker first arrives.

Dialogue #8

(*Knock on front door.*)

1 Client (C): Yeah.
2 Foster care worker (W): Hello, Mr. Bill Green.
3 C: Yeah.
4 W: Yes, my name is John Smith. I'm from Children Services, from foster care services.
5 C: Right.
6 W: I've got an identification here. [*shows identification badge*]
7 C: Is this about my kids?
8 W: Yes, it is, it's about your children. I tried to call last week but found out that your phone was disconnected.

9 C: Yeah, something to do with the bill or something like that…I don't know, it's crazy.
10 W: I understand that there was a preliminary hearing last week—
11 C: Right, right.
12 W: —and that your children were removed.
13 C: Yeah. Do you know anything about that? Were you in on that or something?
14 W: [*being clear about what he knows*] Well, I'm from the foster care services and I do know that your children are in foster care now.
15 C: Yeah, that's what they said at court, that's what that PS (Protective Services) worker woman said at court.
16 W: Right, Right. [being clear about the purpose of his visit] And, so what I'm here do is, I would like to talk to you about what might happen next, and was hoping that I'd be able to set up an appointment with you. I called—, actually, I could meet with you now for forty-minutes or so, if that's a possibility?
17 C: Yeah, I guess, I guess that'd be okay, you know, I'm still real irritated about that whole thing in court, I mean that still is wrong and sounds like if you were in on that, I don't think I want you in my house.
18 W: [*affirming the client's perceptions*] I understand. I talked—, from the PS worker that things did not go the way you wanted to with court.
19 C: No, not at all, not at all. I mean they were just lies upon lies.
20 W: [*accepting the client's perceptions and assuming client has good reasons for them*] Oh, there were?
21 C: Oh yeah, the PS worker was lying and the courts just took it for that. So, are you with her, with PS on this thing?
22 W: [*clarifying his role*] Well, no, no, once children are put into foster care, a foster care worker is assigned to work with the parents to see what the parents want to do about the situation and Protective Service worker is not here with me today and Protective Service worker is not involved at this point, (the PS worker) may come back to court in the future but your case has been assigned to me right now. [*inviting the client's perceptions*] And I understand from what happened in court that you were very upset.
23 C: Oh yeah, yeah, I'm still am and still.
24 W: [*affirming the client's perceptions*] You were very upset with the abuse being substantiated.
25 C: Right, right. There wasn't any abuse but yeah.
26 W: And in fact, the PS worker said that there was even some shouting in the court.
27 C: Yeah, oh yeah, oh yeah, yeah. I wanted my point to be heard.
28 W: Oh, you did. Okay, and you didn't feel as though it was?
29 C: No, no.
30 W: [being explicit about his SF posture toward the client] Well, I would like to listen very carefully to what you have to say.
31 C: Okay.
32 W: [being explicit about his SF posture and purpose toward the client] And would like to try to figure out if we could find a way to work together—
33 C: Yeah.
34 W: —to make happen what you want to have happen, see what you care to do about this situation.
35 C: Okay.
36 W: Would it be possible for us to meet now?
37 C: Yeah, that'll be okay to meet now. It sounds like, you know I don't know you but it sounds like maybe you're being up front with me, like the PS worker wasn't but you're being up front with me, so maybe, yeah, we can meet now.
38 W: I'll try very hard to be straight with you.

39 C: Yeah, that would be helpful.
40 W: All the way through, so there is- no surprises.
41 C: So- I'll certainly will be, I certainly will—
42 W: Okay.
43 C: Yeah, that sounds good, okay, okay. You can come on in now.
44 W: Alright, thank you.

As Dialogue #8 shows, one of the best ways to respect clients in involuntary situations is to genuinely express interest and curiosity in their understandings of their situations. While it is common to hear clients criticize those who are pressuring them into services or therapy, it is important for the clinician simply to listen, accept clients' perceptions, and not take sides. The purpose of the SF clinician is to be a resource to clients and find a way to work together with them; that will only occur if the clinician is willing to hear and respect what is important to clients.

In Dialogue #8, the foster care worker, sitting with the client in the client's home for more discussion, takes a SF approach and focuses on what the client might want:

Dialogue #8 (continued)

45 W: So, let's back up, what's your understanding of—, what's happened here, of this situation?
46 C: I don't know, I'm really not sure. I just know these kids—, my boys are taken from me. All I know, that it was told in court that they're in some foster home.
47 W: Yes, they are.
48 C: Yeah, and I don't know what the story is, you know it's upsetting. I don't know when I'm going to see 'em, you know, it makes-, I know they want to see me. This is all ridiculous, just ridiculous; this is crazy, just crazy. I think the system's just out to make money and that's what they do, take kids to make money off you.
49 W: So, you've said a whole lot here already, one thing that's real clear is that you want to see your children—
50 C: Yeah, I wanna see 'em, yeah. They said that at court, they said at court I'll be able to see my kids each week.
51 W: And before we finish up today we'll talk about that and set up that first visit.
52 C: Yeah, that'll be great because I'll do whatever it takes to see my boys and get 'em back, yeah, whatever it takes.
53 W: [*affirming and accepting the client's goal*] And that's very clear, too, you want those boys back.
54 C: Yeah, absolutely, I want them here, they belong here, they belong here.
55 W: Okay. So, if the PS worker were here, I want to back up a little bit, if the PS worker were here, what do you suppose she would say about how come she took the children?

The clinician, in being curious about and affirming the client's perceptions in involuntary situations, often soon discovers what is important to clients and what they want. Once the clinician and client agree on the client's goal and that they are able to work toward that end, their working relationship begins to look similar to the context of one with clients who have come for services voluntarily, and sessions proceed accordingly.

The use of relationship questions is especially useful and prevalent in working with clients in involuntary situations. Clients in these situations must develop their solutions while taking their contexts into account. Relationship questions are a tool that enables the clinician to incorporate the client's context into the solution-building process in a realistic manner without aligning with those who may have pressured the client into seeking services. In utterance #55, once the clinician and client have co-constructed and affirmed the client's goal, the clinician used a relationship question about the Protective Services worker to begin the process of co-constructing a contextualized solution to what the client wants. Later in their conversation, this foster care worker also asked relationship questions to bring the perceptions of the client's children and the court into the solution building process. More examples of dialogues with clients in involuntary situations and the SF principles and practices of working with these clients are provided in several sources (Berg, 1994; Berg & Miller, 1992; De Jong & Berg, 2001; De Jong & Berg, 2013; Franklin & Kim, 2025; Ratner et al., 2012).

Scope of Practice

SF practices have been documented by numerous authors, highlighting its inherently culturally sensitive approach. This adaptability allows SF techniques to be implemented across diverse populations and countries worldwide. For example, Lee (2003) remarked that, since SFBT theoretical foundations on constructivism promote a non-expert clinician who honors clients' worldviews and strengths, by establishing collaborative therapeutic relationships to process change, the approach is culturally respectful. In addition, authors have reported that the model is suitable for approaches in work with African American and Latino populations as it aligns with the values of kinship and family relationships (Corcoran, 2000; Oliver et al., 2011).

Over the past two decades, the practice and research of SFBT have spread around the world, beyond the frontiers of the United States and Western cultures extending to countries with diverse characteristics, cultures, geographical locations. A worldwide review (Beyebach, 2021) found 365 outcome studies distributed in 33 countries, categorized based on the WEIRD criteria: (W) Western, (E) Educated, (I) Industrialized, (R) Rich, and (D) Democratic; and non-WEIRD countries. About one-third, or 12, of the countries were WEIRD, while two-thirds, or 21, were non-WEIRD, i.e., did not meet at least one of the five criteria. However, the number of publications remains balanced, with 175 studies in WEIRD countries and 190 in non-WEIRD countries. In diversifying research production, most of the studies were conducted in the Northern Hemisphere; by continent, Asia accounted for 44.11%, Europe 20.82%, and the United States and Canada 18.08%. In the Southern Hemisphere, South America accounted for 3.29%, Australia 4.66%, and Africa 1.37%. Additionally, 75% of articles were published in just eight out of the 33 countries, namely the United States, United Kingdom, Finland, Australia, and Netherlands (WEIRD countries), and China, Iran, and Turkey (non-WEIRD countries). The distribution of these studies highlights the rapid global expansion of the application of SFBT. According to Beyebach et al. (2021), this growth may be attributed to the nature of SFBT procedures, which are not based on specific content and emphasize a collaborative, non-expert

therapeutic approach. The current challenge lies in conducting more studies in non-WEIRD countries, particularly in the Southern Hemisphere, that to further demonstrate SFBT's utility and feasibility as a global model that respects the vast diversity of worldviews

COMPARISON WITH OTHER APPROACHES

SFBT utilizes a person-centered lens that focuses on client conceptualizations of behavior, descriptions, and social contexts. SFBT is often categorized with modalities such as Motivational Interviewing (MI) (Miller & Rollnick, 2002; Stermensky & Brown, 2014) due to shared components such as empowering clients in identifying meaningful goals, shared decision-making, supporting the client in shifting towards solutions talk, and use of language. It differs from MI both theoretically and practically by focusing on solution building and what the clients wants to be different in the present and future. For example, SFBT begins where the client is and uses co-constructive sequences to follow the client toward their own solution rather than focus on moving people through the stages of change to build a solution. SFBT is most often associated with Narrative Therapy (e.g., Chang & Nylund, 2013) due to shared conceptual similarities aligned with a positive psychology approach. Both modalities adopt a non-pathologizing stance, are client-focused, and aim to create new realities. Both are also rooted in postmodernism and social constructionism wherein understanding is co-constructed in the therapeutic process through shared observation, experience, and language. There are, however, significant differentiating factors. For example, Narrative Therapy, while encouraging clients to construct desirable futures, emphasizes reframing past narratives and identifying alternative meanings; SFBT on the other hand, utilizes an orientation toward identifying and implementing solutions in the present and future while building on existing client strengths and taking incremental steps toward clients' desired futures.

By adhering to tenets of positive psychology, such as building on client strengths rather than utilization of a pathologizing approach that emphasizes problem-solving, SFBT has distanced itself from any approach which requires "working through" or intensive focus on a problem to resolve it or any approach which primarily focuses on the past rather than the present or future. For example, rather than seek to modify "problematic" emotions or thoughts (e.g., Cognitive Behavioral Therapy), SFBT connects the relationship of the client to their experiences and facilitates access to the client's desired future. As SFBT has developed, the 'problem' that is typically central in traditional cognitive-behavioral approaches has become less significant in the therapeutic process. Instead, SFBT facilitates access to a desired future through collaborative dialogue, focusing on the client's innate strengths, resources, and exceptions, without fixating on the perceived problem.

This strength-based, collaborative mindset is clearly reflected in the SFBT approach to assessment where the client is seen as the expert of their life and experiences. While SF therapists are experts in facilitating the "conversation of change" and guiding the dialogue toward describing an alternative, beneficial reality (de Shazer, 1994), the therapeutic

focus remains on the client's own assessment of their situations, experiences, and desired future. Contrary to models of treatment that embrace a hierarchical relationship in which the clinician possesses expert diagnostic knowledge and clients are objects for assessment, SFBT approaches assessment in a way that acknowledges the client as the "assessor" who self-evaluates:

- the client's desired future;
- feasible solutions to the problem to get closer to the desired future;
- the goals of treatment;
- strengths and resources that can be used to access the desired future;
- what may be helpful in the process of change; and
- commitment or motivation to make change a reality (Lee et al., 2003; Lee, 2013).

While there are some consistencies with other strengths-based therapeutic modalities, SFBT remains unique in its approach to supporting client change through conversational skills that help clients shift toward solutions. As evidenced in microanalysis research examining the details of therapeutic communication, SF therapists utilized significantly more positive than negative utterances and had a high degree of preserving the client's exact words rather than substituting or adding their own words (Jordan et al., 2013; Korman et al., 2013). These findings support the uniqueness of SFBT as a therapeutic approach and reflect the emphasis on positive shared language, that is, viewing the "client as expert" and building on the client's strengths and resources toward their desired future.

RESPECT FOR HUMAN & CULTURAL DIVERSITY

The SFBTA (2023) By Laws affirm the organization's respect for human diversity. Members are asked to adhere to the Association's Diversity & Inclusivity Statement:

> In our mission to expand and further develop solution-focused brief therapy, we realize the importance of both diversity and inclusivity. As an Association, we recognize that our success is dependent upon the engagement, inclusion, and valuing of the rich diversity of all individuals. We acknowledge diversity as it relates to race, ethnicity, gender identity, sexual orientation, veteran status, religious and spiritual beliefs, nationality, political affiliation, and/or physical, mental, and neurological abilities. We are committed to treating all individuals and groups with dignity, respect, and a sense of belonging.

One notable strength of SFBT is its flexibility for cross-cultural application in a way that honors and acknowledges the diverse cultural and human experiences in its various forms (Kim, 2014; Meyer & Cottone, 2013). SFBT is inherently culturally respectful with its focus on clients' construction of problems and solutions as well as the co-construction of solutions and preferred future during the therapeutic process (Lee, 2003). Many psychotherapeutic models face challenges when applied in cultural contexts different from

where they were developed. These approaches often require significant cultural adaptation to maintain their effectiveness in new contexts (Hall & Ibaraki, 2015). A traditional, expert-driven, problem-solving approach expects the clinician to regard diversity in the problem assessment phase, and once the problem is identified, again in the intervention phase. Clinicians are tasked with developing a comprehensive understanding of the values, beliefs, and worldviews of different economic, ethnic, racial, gender, sexuality, and age groups along with their different styles of communication and problem solving. Additionally, clinicians are expected to engage in self-reflection and address their own biases and ethnocentric attitudes as to not assess diversity-based cultural traits as problem deficits or, at the intervention stage, conduct or recommend interventions that may be culturally inappropriate or ineffective. While well-intentioned, the problem-solving approach to diversity-sensitive practice presents several challenges as it is based on expert-derived categories of human diversity that may lead to oversimplification, over generalization, or viewing clients through categories that can inadvertently promote stereotyping. Therapy that is based on categorizing individuals according to diversity markers may unintentionally reinforce stereotyping and potentially jeopardize the overall effectiveness of the therapeutic process.

In addition, therapeutic approaches that focus on classifications and theories of the origins of problems are rooted in the social, cultural, and historical context in which those diagnostic systems and theories were developed. Thus, applying those treatments in other cultural contexts also imports the social and cultural frame used to define the problem, which may not fit the frame of the therapist and client.

There is growing evidence that SFBT can be applied effectively in a wide range of cultural contexts without the need for new development of "culturally adapted" SFBT interventions (Neipp & Beyebach, 2024). SFBT distinguishes itself from other leading approaches in that it does not require cultural adaptations and instead emphasizes strengths and solutions rather than diagnoses and problems. Unlike many other therapeutic modalities, SFBT has not introduced or promoted any categorizations of clients or their difficulties to professional literature and does not employ scientifically-based categories in conducting SF co-constructive sequences. Rather, this approach proceeds one individual session at a time, paying attention to each client's unique construction of their preferred future, their unique related successes, and their unique degrees of progress. In this way, SFBT regards the holistic individual in their complexity and diversity. The SF clinicians' non-expert and not-knowing approach has gained a reputation for its versatility and effectiveness across a diverse social groups and societies. The SFBTA, in alignment with other helping professions, encourages both aspiring and practicing professionals to study and engage with a diversity of persons, groups, and cultures. The purpose in doing so is not to become an expert in diversity-competent assessment and intervention but to enhance the professional's ability to listening more attentively to each client and respond more effectively to what is important to each client, their goals, their successes, and their progress as they themselves assess it (for more on SFBT as diversity-sensitive practice, see De Jong & Berg, 2013; Kim, 2014).

Recognizing the power of therapeutic dialogues and the potentially harmful effects of a pathology-based and deficits-based perspective in sustaining the problem and disempowering clients, SFBT deliberately adopts the language and symbols of "solution and strengths" and fully embraces clients' voices and resources in the search for effective solutions (Lee & Eads, 2024). Consequently, the roots of SFBT in social constructionism and a strengths perspective offer important advantages for its effective application in diverse contexts and with marginalized populations. By eschewing predetermined definitions of the problem in favor of the client's own preferred future and existing strengths and resources, SFBT facilitates a solution-building conversation that could take many forms uniquely suited to each cultural (and individual) context without needing to change the primary ingredients of SFBT. The culturally acknowledging aspects of SFBT have value both when there is difference between therapist and client and when SFBT is conducted in cultural contexts that differ from the context in which SFBT originated.

Finally, a primary focus of culturally respectful treatment is an emphasis on cultural humility without which any therapeutic modality can perpetuate the power dynamics and oppression of broader societies within the therapeutic relationship. At its core, SFBT attempts to lessen the power imbalance between therapist and client by positioning the client as the expert of their own reality and empowering them to set the agenda for the solution-building process. Additionally, effective SFBT practice inherently involves curiosity about the client and their situation—curiosity about their strengths, successes, and desired future. This curiosity aligns well with cultural humility in its emphasis on openness to aspects of diversity and difference in the perspectives, values, and priorities of the client compared to the therapist's own frame of reference. By framing reality as fluid, changeable and shaped by language, SFBT encourages development of shared language and understanding in the solution-building process whether there is cultural difference between the therapist and client; however, this perspective holds particular value when there are significant differences between the therapist and client. Additionally, the emphasis on strengths in SFBT can be helpful in countering discriminatory narratives that consistently problematize minoritized groups (Kim, 2014; Ouer, 2016). SFBT therapists should intentionally maintain their stance of curiosity, their belief in the strengths and resourcefulness of all clients, and their emphasis on the client's preferred future as the driver of the conversation to help facilitate their respect for human diversity and cultural humility in their practice. Research evidence supports the effectiveness of SFBT with groups commonly impacted by discrimination and oppression, including American Indians, Latinos/x, and the LGBTQIA+ community (González Suitt et al., 2016; Meyer & Cottone, 2013; Ouer, 2016), among others (Kim, 2014).

One specific SFBT technique that does contain culturally specific ideas is the miracle question. It may be appropriate to use alternative wording or terminology in this technique to convey the idea of the sudden disappearance of the problem in a way that is compelling to the client (Lee et al., 2022). However, general ideas to "do more of what is working"

and to describe in detail the client's own preferred future may translate well across many cultural contexts without adaptation.

EVIDENCE BASE

Over the last 30 years, there has been substantial growth in the evidence base of SFBT in terms of both intervention effectiveness and mechanisms of the change process. Though core aspects of SFBT were discovered inductively through close observation of what works in therapy (de Shazer et al., 1986; Weiner-Davis et al., 1987), the principles and techniques of SFBT have since been subjected to rigorous testing across numerous practice areas and contexts. According to the European Brief Therapy Association, by 2024 SFBT had been the subject of more than 600 journal articles, including more than 100 randomized controlled trials (RCTs) published between 2005 and 2023 alone. A systematic review of the global literature on SFBT identified and assessed 251 published outcome studies and 91 RCTs and found results supporting the effectiveness of SFBT in 73% of RCTs and 86% of outcome studies overall (Neipp & Beyebach, 2024). The findings in the systematic review represents remarkable growth in SFBT literature since the early 2000s when only a handful of well-controlled studies could be identified in the first systematic reviews of SFBT (Corcoran & Pillai, 2009; Gingerich & Eisengart, 2000). With this substantial base of SFBT outcome studies, SFBT can now be considered an evidence-based practice (Kim et al., 2010; 2019).

The substantial number of controlled studies has also enabled a growing number of systematic reviews and meta-analyses to assess the magnitude of the effect of SFBT and the evidence for SFBT applied to specific topic areas (see Appendix for examples of the reviews). Systematic reviews offer the advantage of comprehensively surveying the existing research for SFBT in a particular focus area to assess the evidence for using SFBT. The first systematic review to focus on a specific topic area was conducted by Kim and Franklin (2009) and assessed the research on SFBT in schools. The review found promising results but only one RCT. By 2013, the SFBT literature had grown, enabling a systematic review supporting the general effectiveness of SFBT now based on 26 RCTs (Gingerich & Peterson, 2013) with 74% of controlled studies showing significant benefits of SFBT, as well as a systematic review of SFBT for children and families that found evidence of SFBT benefits specifically for externalizing and internalizing behavior problems in children now based on 38 outcome studies (Bond et al., 2013). Since 2016, systematic reviews have been conducted reviewing the evidence for SFBT with Latinos (6 studies; González Suitt et al., 2016), intellectual disabilities (12 studies; Carrick & Randle-Phillips, 2018), trauma survivors (5 studies; Eads & Lee, 2019), and substance use problems (9 studies; Franklin & Hai, 2021), each finding promising evidence but calling for more rigorous studies in each area. By 2024, an umbrella review identified 25 systematic reviews that had been conducted on SFBT with all reviews reporting positive outcomes for SFBT and particularly strong evidence of benefits for depression, mental health, and progress towards goals in adult clients (Żak & Pękala, 2024).

Even stronger evidence of SFBT effectiveness comes from systematic reviews that use meta-analysis to statistically combine the results from a pool of studies into a single estimate of the size of the effect of SFBT. Meta-analyses typically report effect sizes in standard deviation units using Cohen's d or Hedges' g and represent the average size of the difference in outcomes between receiving SFBT or being in a control group. Typically, effect sizes of at least 0.20 are considered small, at least 0.50 are considered medium, and 0.80 and above are considered large effects (Cohen, 1988). The first meta-analyses on SFBT were conducted by Stams et. al. (2006) and Kim (2008). Stams et al. (2006) examined twenty-one studies, with N = 1,421, and yielded significant and positive results showing small to medium effect sizes d = 0.37 (95% *CI*: $0.19 < d < 0.55$). Moderator analyses revealed that SFBT had a positive effect if compared to no-treatment, d = 0.57, but that the effect was not significantly larger than the effect of treatment as usual: d = 0.16. Moderator analyses also revealed that adults benefited more from SFBT (d = 0.61) than did children and adolescents. Clients residing in institutions, such as prisons, benefited more from SFBT (d = 0.60) than did non-residential clients such as families and couples (d = 0.40) and students (d = 0.21). Externalizing behavior problems showed a larger effect (d = 0.61) than marital problems (d = 0.55), internalizing problems (d = 0.49), or mixed problems (d = 0.22). Group therapy clients had better outcomes (d = 0.59) than did individual therapy clients (d = 0.33). Finally, the effect of SFBT was larger for non-controlled studies (d = 0.84) than for controlled studies (d = 0.25).

Kim's (2008) meta-analysis found an effect size of 0.26 favoring SFBT over comparison groups, which aligned with effect sizes usually found in evidence-based psychotherapy research (Wampold, 2015). By 2024, at least 10 meta-analyses had been conducted on SFBT finding a range of effect sizes supporting small to large effects of SFBT in a variety of areas. Meta-analyses have found small to medium effects of SFBT in the areas of internalizing symptoms (d = 0.31; Schmit et al., 2016), medical settings (d = 0.34; Zhang et al., 2018), child behavior problems (g = 0.43; Hsu et al., 2021), parent training groups (d = 0.58; Carr et al., 2015), and community-based services (g = 0.65; Franklin et al., 2024). Finally, three meta-analyses have looked at the international literature for SFBT in school settings and have resulted in a wide range of effect size estimates from small to very large (0.18 to 1.80; Franklin et al., 2022; Gong & Hsu, 2017; Karababa, 2024). A recent comprehensive meta-analysis on the effects of SFBT on psychosocial outcomes included 79 studies and is the first meta-analysis to include a detailed moderator analysis across a large number of SFBT studies. The overall effect of SFBT on psychosocial problems was large (g = 1.17) and included a range of psychological and behavioral outcomes. Moderator analyses revealed larger effects of SFBT in non-clinical samples (g = 1.50) than in clinical samples (g = 0.78). The implications meaning that SFBT is especially efficacious in early intervention and with at-risk populations. Studies with treatment-as-usual (TAU) as control condition reported smaller effects (g = 0.58) than studies with a no-treatment control condition (g = 1.59). Relatively large effects were found for couples counseling in a group modality (g = 3.02) compared to other client groups ($0.41 < g < 1.70$), and marital functioning (g = 3.02) compared to other outcomes ($0.23 < g < 1.31$). Group

therapy (g = 1.64) yielded a larger effect than individual therapy (g = 0.48) (Vermeulen-Oskam, Franklin, et al., 2024)

The growing literature on SFBT has provided additional breadth and confidence for the evidence base for SFBT, which now includes systematic reviews and meta-analyses of SFBT in various international contexts. As indicated earlier, the global growth of SFBT research in recent years has been remarkable. In fact, by 2021, the number of SFBT studies from non-Western contexts—especially China, Iran, and Turkey—had exceeded the number of SFBT studies from the Western contexts—namely the United States and Europe—in which SFBT originated and was first researched (Beyebach et al., 2021). Systematic reviews and meta-analyses have now been conducted focusing on SFBT research from specific countries, including China (Franklin et al., 2022; Gong & Hsu, 2017; Gong & Xu, 2015; Kim et al., 2015) and Turkey (Bilgin, 2020; Karababa, 2024). Generally, international meta-analyses have reported large effect sizes favoring SFBT, estimating effect sizes of 1.07 to 1.26 in Chinese studies (Gong & Xu, 2015; Kim et al., 2015) and 1.80 in a meta-analysis of studies on adolescent school problems that were mostly conducted in Turkey (Karababa, 2024). In an umbrella review of 15 meta-analyses conducted by 2024, Żak & Pękala (2024) found an overall effect size of 0.65 for SFBT that differed between Western (0.37) and Eastern (1.07) meta-analyses. The authors noted that studies in Eastern meta-analyses were more likely to use passive control groups (e.g., no treatment) compared to studies in Western meta-analyses that were more likely to compare SFBT to other active treatments with passive control groups identified as a moderator associated with larger effect sizes across all meta-analyses (Żak & Pękala, 2024).

In addition to the substantial outcome literature on the effectiveness of SFBT, there has been growing literature investigating the process and mechanisms through which SFBT helps generate change. Franklin and colleagues (2017) completed a systematic review and meta-summary of the process research in SFBT based on 33 studies of the change process in SFBT. The review identified the strongest evidence for positive benefits of the collaborative language of SFBT in the co-construction of meaning and for the strengths and resource-oriented techniques, such as assessing for pre-session change, scaling questions, and exception questions. Other scholars have noted evolution over time in the practice of SFBT and placed more emphasis on detailed description of the preferred future and presuppositional language but retained emphasis on the core principles and philosophy of a solution-focused approach (Froerer et al., 2023; McKergow, 2016). In general, there is greater commonality among SFBT studies in terms of the perspective of SFBT, including emphasis on strengths, exceptions, and preferred future, than there is for the use of specific techniques such as between session tasks, scaling, or compliments (Jerome et al., 2023). Franklin et al. (2024) provided that the most efficacious results were achieved when clinicians used techniques across categories of potential techniques (e.g., collaboration and co-construction, strengths and resources, and future focused techniques) and did not use more than eight techniques. Though the evidence base for SFBT now includes empirical support for the positive benefits of various techniques associated with SFBT (Franklin et al., 2017), the flexibility of the broader perspective of

solutions and strengths may aid its widespread applicability in many practice areas in settings across the globe (Beyebach et al., 2021; Neipp & Beyebach, 2024).

FIDELITY ENHANCEMENT, MONITORING, & REPORTING IN SFBT RESEARCH & PRACTICE

The extent to which essential components of behavioral interventions are delivered during research and practice has an impact on the wellbeing of the people who are participating in them. This principle applies to counseling and psychotherapy methods like SFBT. Research indicates there is little consistency among studies in the conceptualization and reporting of intervention fidelity or integrity strategies among behavioral interventions in the peer-reviewed literature (Prowse & Nagel, 2015). Results provide that some interventions can be diluted upon implementation, that is, providers may drift from the original intentions of the interventions or methods in both research and practice. Some form of flexible and adaptable adherence to an intervention's key components has been recommended, and frameworks for doing so have been laid out by groups like the National Institutes of Health's Behavior Change Consortium (Bellg et al., 2004).

It has been recommended that a combination of fidelity enhancing strategies, including provider self-checklists, treatment manuals, training and education for providers, be utilized before and during intervention delivery. It is also recommended that fidelity checklists be evaluated for reliability and validity and that the results be reported in research publications and trainings. Recently, some authors are considering moving beyond simple provider self-administered checklists that are completely quantitative to include the addition of qualitative reports of how the intervention was adapted, delivered, and experienced by clients or participants (Toomey et al., 2020). The implications for practice are also important to consider as providers who are learning to utilize models like SFBT can benefit from reflecting on the techniques and mindsets they utilized in their sessions as well as from the experience of delivering to enhance their therapeutic skills.

Summary of Fidelity in 2013 SFBT Treatment Manual

The previous SFBT Treatment Manual (Bavelas et al., 2013) laid out the basic processes and ingredients of SF practice as it was described by Berg, De Jong, de Shazer and others beginning in the 1980s (De Jong & Berg, 2013; De Jong et al., 2013; de Shazer, 1985; de Shazer et al., 2007). Although specific fidelity measures of those processes and ingredients were not prescribed in the manual, examples of applications in therapeutic conversations were provided. The ingredients described in the previous manual included: centering client conversations around the preferred future; understanding the client's meaning through therapeutic questions; and further questions to co-construct a client-centered vision of the preferred future based on past strengths, successes, and resources of the client (Bavelas et al., 2013, p. 8).

The previous manual lists the specific active ingredients of SFBT including: use of a therapeutic alliance with the client, solution focus vs. problem focus, future-focused discussions, scaling progress, and focusing on exceptions to the problem (Bavelas et al., 2013, p. 10.) Further specific interventions mentioned in the manual and based on writings from de Shazer et al. (2007) include giving compliments, gentle nudging toward what is working, pre-session change, and the miracle question (p. 12-13).

Summary of Published SFBT Fidelity Monitoring Methods

According to Lehmann and Patton (2012), solution-focused methods are flexible and amenable to adapt to specific practice settings, providers, and populations. This flexibility has enhanced the client-centered nature of the methods and was highlighted by Franklin et al. (2017) as one of the key successes of SFBT research studies. The collaborative process of co-construction of the client's desired outcomes, goals, and solutions is grounded in social constructionist theory. In the context of evaluating clinical and research efforts, Lehmann and Patton (2012) indicated a need for including the major tenets, techniques, and mindsets of SFBT in a quantitative checklist that could be used to measure the level of SFBT content in sessions. They recommended that SFBT researchers and clinicians take fidelity measurement seriously to ensure that the true nature of the practice is reflected in learning and studying the outcomes of SFBT. The resulting Solution Focused Fidelity Instrument (SFFI) was created, and has proven to be a reliable scale (α=.88) (Lehmann & Patton, 2012) (see Appendix A).

Recent Developments in SFBT Fidelity

Recently, SFBT researchers have been describing the strategies used to enhance fidelity to SFBT in their studies, including the use of trainings, manualized interventions, checklists for monitoring techniques used, and reporting the amount of service received. In their study of an SFBT counseling intervention for individuals with substance use disorders, Kim et al. (2021) enhanced fidelity to SFBT through the use of trainings, the SFFI, and an adaptation of a supervisor observation form developed by Smock and others (2008). They found that participants decreased their substance use with good adherence to the SFBT techniques by providers and adequate uptake of SFBT skills by participants (Kim et al., 2021).

Similarly, Yates and Mowbray (2021) documented SFBT fidelity enhancing and monitoring strategies in their study of an SFBT wellness intervention for women living with HIV. They noted fidelity enhancing strategies encouraged by the BCC framework (Bellg, 2004) including the use of a treatment manual adapted for the specific population with session-by-session instructions that prompted the use of SFBT mindsets and techniques (Yates et al., 2019). They also noted provider training in SFBT prior to the start of the intervention. Based on the SFFI, the researchers adapted a fidelity measure to quantify the extent to which each SFBT mindset and technique was utilized in a single session. The researchers found that good adherence to SFBT was noted alongside positive gains in the primary outcome of multidimensional wellness (Yates & Mowbray, 2021).

A recent mixed-methods study by Cooper and Johnson (2025) that utilized an SFBT intervention within an Integrated Care Model in a primary care setting outlined how fidelity to the model was enhanced and measured during the study. The researchers discussed use of training and consultation in SFBT prior to implementation as well as measures of dosage and duration of sessions (how much SFBT was received); use of session templates to ensure adherence to SFBT techniques; a provider self-report checklist to monitor intervention integrity; and a scale to analyze the uptake of specific SFBT skills. They found significant differences between the treatment and comparison groups as well adequate intervention fidelity according to the checklist and scale (Cooper & Johnson, 2025).

Plans for the Future of SFBT Fidelity

Fidelity or integrity to the SFBT model is a growing area of discussion among researchers and clinicians, and recommendations or frameworks for improving its utilization in behavioral interventions are widespread in the peer-reviewed literature (Bellg, 2004; Prowse & Nagel, 2015). Several SFBT fidelity checklists have been created, adapted, and tested for reliability and validity and are available for trainers and trainees, clinicians, and researchers (Cooper & Johnson, 2025; Lehmann & Patton, 2012; Yates & Lee, 2021).

Additional fidelity enhancing methods that move beyond checklists of techniques are also important for ensuring integrity to the SFBT model and are continuously being adapted and improved. They include adequate training, the use of treatment manuals and session templates, the measurement of how much of the intervention was provided (referred to as dosage and duration), and the measurement of uptake of skills by clients after the intervention. Researchers in related behavioral fields are exploring qualitative methods for documenting the experience of delivering and receiving services to enhance treatment integrity (Toomey et al., 2020). These fidelity enhancing efforts are necessary for researchers and clinicians to ensure that changes being observed in clients who engage in services are due to the model rather than other factors. We recommend that SFBT researchers and clinicians share their fidelity enhancing and monitoring strategies so that others can benefit from advances in integrity to the model.

COMPATIBILITY WITH ADJUNCTIVE THERAPIES

In addition to its effectiveness as a stand-alone therapeutic approach, the principles and techniques of SFBT can also be useful alongside or integrated with other approaches. There is a general imperative in SFBT to “do more of what is working,” that is, if a client already finds a certain treatment helpful, such as taking medication or attending a self-help group, then the SF therapist would encourage the client to continue the behaviors engaging in those behaviors. SFBT can also be valuable when incorporated into other treatment settings, such as medical settings (Zhang et al., 2018), child welfare and foster care

(Cepukiene & Pakrosnis, 2011; Koob & Love, 2010), or substance use treatment (Franklin & Hai, 2021; Kim et al., 2018).

As research on SFBT continues to grow in its scope and breadth, there has also been increasing attention to intentional integration of SFBT with other approaches and therapies. This includes delivering SFBT in alternative or creative formats that may be helpful for clients as well as combining SFBT techniques with compatible approaches for promoting wellness, such as mindfulness and other holistic interventions. Given the individual context and preferences of a client, it may be appropriate to engage in solution-building communication in ways that extend beyond talk therapy. One such example is using solution-focused art therapy (Moosa et al., 2017; Yang & Kim, 2015) to facilitate the solution "conversation," which may be beneficial for clients who are less advanced verbally, such as children and adolescents. Further, the signature SFBT technique of the miracle question centers around helping a client envision as clearly as possible their future reality without the problem, and creative expression such as art offers unique ways for the client to depict their desired future in ways that access different regions of the brain than using language (van der Kolk, 2014). A further example of using alternate methods to engage in a solution-focused communication process is the use of hypnotherapy in conjunction with a solution-focused process as described in a case study with a survivor of child sexual abuse (Sánchez & Téllez, 2016). While further validation through outcome research is needed to demonstrate the effectiveness of specific ways of extending the solution-focused conversation beyond regular talk therapy, the SFBT principles and philosophy, which call for engaging with the client using the "language" that works best for them, should include consideration of creative and alternative forms of communication as appropriate.

Finally, in recent years, there has been increasing attention to the conceptual alignment between SFBT and holistic body-mind-spirit approaches to wellness (Gehart & Paré, 2008; McCollum, 2005). More recently, SFBT has been integrated with techniques such as mindfulness, compassion meditation, qigong, and yoga (Eads, 2023). Viewing one's body, mind, spirit, and relationships as interconnected and inseparable aligns with the systems perspective of SFBT and potentially offers new avenues for generating small changes and noticing differences. For example, a brief mindful breathing exercise could be used as a between-session task to generate a new alternative to a "problem" reaction in a relationship or as a between-session task focused on noticing what happens in a situation to include noticing what is going on in the body. Similar to using art to engage the brain in describing the preferred future in new ways, using an integrated technique of guided meditation around the miracle question could further deepen the experience of envisioning and embodying the reality without the problem (Eads, 2023). Again, additional outcome research on specific integrative interventions that incorporate SFBT is warranted to further establish compatibility of SFBT with adjunctive therapies.

THERAPIST CHARACTERISTICS & REQUIREMENTS

Much like how traditional therapy approaches prescribe treatment to problems or diagnoses, therapist characteristics are prescribed for the appropriate delivery of the approach to a client population. As described in previous sections, SFBT alters the traditional paradigm of prescription-diagnose treatment in psychotherapy by shifting its area of curiosity to 'what works' in and from therapy for the specific client in question, eliciting descriptions befitting this shift by placing greater emphasis on the therapist's competency to adapt to a given client (De Jong & Berg, 2013). As such, SFBT welcomes a wide array of therapist characteristics and utilizes those characteristics for the benefit of the client as described by the client's feedback and preferences. This section, therefore, reflects the efficiency of the solution-focused approach by spending less time delving into arbitrary characteristics and dedicating more time to what a SF therapist must be willing to do with their unique characteristics and competencies in working with their client. This intentional, conscious choice all therapists make in committing to a disciplined SFBT mindset is easy to learn and hard to master (Lipchik, 2002).

Mastery in traditional approaches may be attributed to the development of certain therapist characteristics—unconditional positive regard, empathy, collaboration, and so forth. These characteristics are often described as a means to an end—the end of building client trust to elicit compliance with the therapist's agenda (de Shazer, 1984). What makes a difference in SFBT is how a therapist employs these constructs to build a relationship with their client that best fits the client's good reasons for attending sessions (Pichot & Smock, 2009). The therapist builds an understanding of what is important to the client, what they want from therapy, and what resources the client has at their disposal to recognize the presence of possibility in their life (De Jong & Berg, 2013). This is a process of complimentary competency, of evoking and amplifying a client's voice from the first service enabled by a therapist's willingness to follow the client's direction of what they wish to come from therapy (de Shazer, 1982a). Thus, the therapist must be willing to utilize empathy to demonstrate understanding of what the client wants from therapy, clarify that understanding, and remain dedicated to the client's descriptions (Turnell & Lipchik, 1999). Such an interweave of mutual respect is only possible through collaboration wherein the therapist encourages the client to recognize what is already present and cultivate hope by deciding to engage in therapy (Thomas & Nelson, 2007).

Elicitation of a client's own description echoes the critical nature of SF therapists' use of humility, i.e., their deference to a client's agenda (Lipchik, 2002). In the solution-focused paradigm, the therapeutic relationship is built and sustained through a communicated belief by the therapist observed through numerous forms of feedback in the system of interaction between therapist and client. The clients' expertise and competencies are critical to the work at hand and take precedence over the therapists' own knowledge and expertise on client issues (de Shazer, 1984). This framework fundamentally differs from traditional models, which suggest that rapport building is essential for gaining a client's

trust in order to proceed with the therapist's agenda and that the therapist is a subject matter expert on the client's presenting problem (Berg & Miller, 1992). The therapist's only agenda is their usefulness to the client through the prior mentioned communicated belief in them and deference to the client's agenda for services (Pichot & Smock, 2009). In light of this practice, SF therapists must become curious about clients' prior experiences with therapy (Lipchik, 2002). They must be willing to adapt to what a client has previously experienced as helpful and to the exceptions that have previously enabled change (Fiske, 2008). Without the acknowledgement that a previous therapist's approach may have failed a client in the past or that a particular therapist's strengths (i.e., characteristics) may be ill-suited to this client, SF therapists risk making the same mistakes of previous therapists by assuming there is nothing to explore. Humility becomes a hedge between helpful and unhelpful collaboration and subsequent influence in the therapeutic relationship that will illicit lasting change, for better or worse, for this client. SFBT elicits and amplifies what works. SF therapists must adapt their skillsets and elicit and amplify their strengths and characteristics to build a difference with their clients.

SF therapists demonstrate trust in their clients' capacity to recognize good solutions for themselves within the boundaries of their licensure and ethics (Lipchik, 2002). Valuing a client's identification of what works for them is influenced by a solution-focused mindset, which encourages therapist competency applied to client service as defined by the client. In accordance to applying belief in the client, SF therapists may commit to a disciplined mindset and being-set of solution-focused work through demonstrated confusion and skepticism at a client's expressed helplessness or problem-centric lack of agency, descriptions, and linguistics (de Shazer et al., 2007). This same competent and experienced therapist demonstrates this confusion and skepticism with the appropriate pacing, humility, and respect for the client's challenges, language, and expertise of the difficulties they face (Fiske, 2008; Turnell & Lipchik, 1999). They both recognize what the client is saying and hold space for what is unsaid (de Shazer, 1991). SF therapists makes use of what is being unsaid through a willingness to look at the totality of pattern and circumstance beyond what clients express and elicit through curiosity of the clients' own descriptions of difference (de Shazer, 1982a). Inclusivity of the totality of possibility actualizes the competence of both therapists and clients alike as they construct differences together with all materials at their disposal, including the clients' descriptions and the therapists' unique characteristics that evoke those descriptions.

SFBT's emphasis on welcoming all client resources and competencies while demanding only certain characteristics of therapists would be incongruent, a dissonance unable to stand within its own framework. To list fixed characteristics of a SF therapist is to follow the same problem-focused paradigm, the same linear formula, of traditional psychotherapy approaches that do not acknowledge utility but rather prescribe what an aggregate dictates (De Jong & Berg, 2013). Each therapist who utilizes SFBT is making a conscious decision to shift their reflective processes in therapy away from the client to include a self-evaluation of their own unique strengths, characteristics, and skills in service to their client's informed view (Duncan, Hubble, & Rusk, 1994). The characteristics of an

SF therapist are more aptly described by the ways in which the therapist applies their competencies and their agency in working with their clients' visions of a brighter tomorrow. SFBT is a discipline, a daily and life-long art that yields a helper who takes stock of what they have, recognizes potential, and applies them to what their clients define as useful through humble collaboration.

TRAINING & SUPERVISION OF THERAPISTS

Solution-focused approaches have been used and researched in a wide range of professions and contexts (Neipp & Beyebach, 2022). This treatment manual focuses primarily on formal psychotherapy using the SFBT model as described by de Shazer and colleagues (2007). Therapists providing SFBT should meet the qualifications and licensure requirements to provide therapy sessions with clients as set by their relevant jurisdiction or licensing board. While degree expectations vary internationally, therapists should ideally possess a master's degree in a mental health-related profession (e.g., Social Work, Psychology, Marriage & Family Therapy, Counseling) and receive formal training and supervision in SFBT. A brief outline of such a training program would include:

- History and philosophy of SFBT
- Basic tenets of SFBT
- SFBT therapeutic process
- Essential and complementary components of SFBT
- Session format and structure of SFBT
- Key practices of SFBT
- Practice challenges in SFBT
- Video examples of "Masters" conducting SFBT
- Role play practice by learners which is video recorded
- Peer and instructor feedback around learners' video recorded role plays
- Supervision focused on learners' video recorded role plays and cases

Steve de Shazer stated the following about how to learn and improve one's SF skills: "Therapists are interested in the *doing* of therapy and, at least in a certain sense, only the observation of sessions or watching videotapes of therapy sessions can give them the 'data' they need [to learn SFBT and improve their practice skills]" (1994, p. 65). It is not surprising that de Shazer would emphasize that learners should directly observe live and recorded sessions because the method reflects how de Shazer and the team at BFTC originally invented their approach with clients in SFBT in the 1980s. The contributors to this revised manual agree that the key to learning and improving SF skills is the *direct observation* of the therapist and client in interaction under the supervision of seasoned SF clinicians/supervisors.

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APPENDIX A. EXAMPLES OF SYSTEMATIC REVIEWS OF SFBT OUTCOME STUDIES

Descriptive				
Author	**Year**	**Focus**	**Number of Included Studies**	**Key Findings**
Gingerich & Eisengart	2000	General Effectiveness	15 (4 RCTs)	4 out of 5 well-controlled studies supported SFBT, but more rigorous studies needed to support SFBT efficacy
Corcoran & Pillai	2009	General Effectiveness	10 (5 RCTs)	5 out of 10 controlled studies had at least small effect sizes supporting SFBT efficacy, 2 studies had large effects
Kim & Franklin	2009	Schools	7 (1 RCT)	Review found mixed but promising evidence for the usefulness of SFBT in schools; more rigorous studies needed
Gingerich & Patterson	2013	General Effectiveness	43 (26 RCTs)	32 out of 43 (74%) controlled studies reported significant benefits of SFBT; SFBT helpful for depression and needed fewer sessions than other therapies
Bond et al.	2013	Children and Families	38 (10 RCTs)	Few (5) high-quality studies identified, preliminary evidence of SFBT benefits for externalizing and internalizing problems in children
González Suitt et al.	2016	Latinos	6 (3 RCTs)	Mixed but promising evidence for SFBT with Latinos in practice areas of adult mental health, schools, and couples; more rigorous studies needed
Carrick & Randle-Phillips	2017	Intellectual Disabilities	12	Review found mostly case studies supporting SFBT with mild ID and to support cases; more rigorous studies needed
Eads & Lee	2019	Trauma Survivors	5 (2 RCTs)	Review found limited but promising evidence for SFBT with survivors of trauma; more rigorous studies needed
Bilgin	2020	Studies in Turkey	26	A review of mostly masters (4) and doctorate (20) theses showed significant benefits of SFBT in 25 out of 26 studies conducted in Turkey
Franklin & Hai	2021	Substance Use	9 (3 RCTs)	All nine studies showed promising evidence of SFBT improving substance use and related outcomes; RCTs showed similar benefits as other treatments

Neipp & Beyebach	2024	General Effectiveness	251 (91 RCTs)	Global review found SFBT was effective in 86% of outcome studies and 73% of RCTs; Mixed results when compared to other active treatments

Meta-Analysis				
Author	**Year**	**Focus**	**Number of Included Studies**	**Effect Sizes**
Kim	2008	General Effectiveness	22 (11 RCTs)	Internalizing problems: d = 0.26 Externalizing problems: d = 0.13
Kim et al.	2015	Studies in China	9 (6 RCTs)	g = 1.26 (95% CI: 0.89 – 1.68)
Gong & Xu	2015	Studies in China	33	d = 1.07
Schmit et al.	2016	Internalizing Symptoms	26	SFBT vs. alternate treatments d = 0.24 (95% CI: 0.06 – 0.42) SFBT vs. waitlist/no treatment d = 0.31 (95% CI: 0.09 – 0.53)
Carr et al.	2016	Parent Training	10 (6 RCTs)	d = 0.58
Gong & Hsu	2017	Schools in Taiwan and China	24	d = 1.03 (95% CI: 0.78 – 1.28) Internalizing problems: d = 1.06 (95% CI: 0.80 – 1.30) Family/relationship problems: d = 0.94 (95% CI: 0.30 – 1.57)
Zhang et al.	2018	Medical Settings	9 (all RCTs)	Psychosocial outcomes: d = 0.34 Behavioral outcomes: d = 0.28 Functional outcomes: d = 0.21
Franklin et al.	2019	Schools in U.S. and China	50 (37 RCTs)	d = 0.18 (95% CI: 0.12 – 0.24) English studies: d = 0.11 (95% CI: 0.03 – 0.18) Chinese studies: d = 0.23
Hsu et al.	2021	Behavior Problems in Children and Adolescents	20 (9 RCTs)	g = 0.43 (95% CI: 0.20 – 0.67) Externalizing problems: g = 0.43 (95% CI: 0.18 – 0.68) Internalizing problems: g = 0.18 (95% CI: -0.01 – 0.38)
Franklin et al.	2024	Community-Based Services	28 (all RCTs)	g = 0.65 (95% CI: 0.39 – 0.92)
Karababa	2024	Adolescent School Problems	9 (5 RCTs)	g = 1.80 (95% CI: 0.94 – 2.66)

Note. All studies in meta-analyses were controlled studies (either experimental or quasi-experimental). The number of randomized studies is provided when noted by the authors. Positive values for effect sizes indicate that results favor SFBT over the comparison condition. Effect sizes are reported in standard deviation units (Cohen's d or Hedges' g) with the 95% confidence interval shown when available.