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The Origin of the Solution-Focused Approach

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Abstract

The solution-focused approach to therapy and coaching has its roots in the work done by therapists in the second half of the twentieth century. This article discusses some important precursors, such as Milton Erickson and the Mental Research Institute. Further, it shows how the members of the Brief Family Therapy Center, led by Insoo Kim Berg and Steve de Shazer, developed the core of the solution-focused approach in the 1980s. Key concepts and publications are discussed and a description is given of how the team members worked together closely to find out what works in therapy.

Keywords: solution-focused, BFTC, solution-focused history, de Shazer, Berg

The solution-focused approach is now an established psychotherapy and coaching approach for which there is a good evidence base (Franklin, Trepper, Gingerich, & McCollum, 2011; Gingerich & Peterson, 2013). Both solution-focused interventions such as the miracle question, scaling questions, coping questions, and exception-seeking questions, and solution-focused assumptions, such as that there are always exceptions to problems and that clients already have solutions to their problems, are now relatively well known among therapists and coaches. The aim of this article is to show that, while the roots of many of these practices go back to the 1950s or thereabouts, the real hotbed of these innovations was a think tank called the Brief Family Therapy Center in Milwaukee, Wisconsin (US), which, in a burst of collective creativity led by the innovative therapists Insoo Kim Berg and Steve de Shazer, created the core of the solution-focused approach in the first half of the 1980s.

Precursors to the Solution-Focused Approach

During the middle of the previous century, change was in the air. This was also the case in the profession of psychotherapy. Many psychotherapists were dissatisfied with traditional views on psychotherapy. Since its emergence as a discipline, the dominant view had been that psychotherapy had to focus on problems and problem causes (Walter & Peller, 2000). The therapist was seen as the expert who would expose the nature and the causes of the problem so that it could be solved. Causes were thought to be hidden away deep in the psyche of the patient and were often related to unresolved problems in early childhood (Seligman, 1990). Furthermore, patients were generally thought to resist treatment unconsciously. What patients directly told about their problems and goals, therefore, had to be taken with a pinch of salt. The most useful information was thought to be information that trickled through from the unconscious. To obtain that information, psychotherapists used techniques like dream analysis and interpretation, hypnosis, drugs, and different kinds of projective techniques.

Psychotherapy usually took a long time and did not tend to be very pragmatic and goal-oriented. A funny parody illustrating this is a scene from the movie *Annie Hall* by Woody Allen:

> Woody Allen plays Alvey Singer (…) who tells his girlfriend Annie he has been in therapy for thirteen years. Yet it is clear he still has many problems. Annie asks, surprised, why there is little improvement after so much therapy. Alvey responds that he intends to give it fifteen years, and if he has not gotten any results by then, he is going to visit Lourdes. (O'Hanlon, 2000, p. 2)

Halfway through the previous century, several therapists were looking for ways to make therapy briefer, more goal-oriented, and more pragmatic. The dominance of behaviorism within psychology played a critical role in this

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(see, for instance, Skinner, 1938 and Watson, 1913). Behaviorism had dissociated itself from psychoanalysis and focused on intervening in concrete, observable behaviors. Albert Ellis was a well-known therapist who developed a more pragmatic form of therapy, rational emotive therapy (RET; Ellis, 1962). Within this form of therapy, problems were thought to be maintained by irrational beliefs of the client. By identifying and then replacing these irrational beliefs with more rational ones, the problem could be solved. The ideas on pragmatism that William James (1907) had formulated decades earlier had regained popularity both in science and in society, and were another source of influence to many therapists of that time. The pragmatists suggested shifting the emphasis from trying to explain and predict truth to identifying and using what works. James argued that people are creators of reality. This way of thinking certainly played a role in the work of another pioneering therapist.

Milton Erickson

This pioneering therapist was *Milton Erickson*. He was an American psychiatrist who had quite a few unorthodox ideas about therapy, which he used successfully (Erickson, 1980; Erickson & Rossi, 1979; Rosen, 1982). We now know that many of his ideas pointed forward to the principles of the solution-focused approach. Erickson did not believe in diagnostic labels and strongly believed in the power of people to solve their own problems. He was convinced that therapy often did not need to take long and believed that a small change by the client was often enough to set a process of larger change in motion. Erickson also used paradoxical techniques such as prescription of the symptoms. Characteristic of his approach was that he used whatever was there in the context of the client: each seemingly coincidental feature or event in the life of the client could turn out to be part of the solution.

In a typical illustration of how Erickson viewed life, he once said the fact that he had had polio at age 17, which totally paralyzed him, had been an important advantage to him. The reason he said this was that he was convinced it had helped him to become very good at observing other people. Instead of complaining about his situation, he accepted it and turned it into an advantage. He is said to have conquered his paralysis later by teaching himself step by step to move again. By the way, besides having been paralyzed, Erickson is said to have had quite a few other limitations: he was colorblind, dyslexic, tone deaf, and arrhythmic (Cade, 2007).

Gregory Bateson was another influence on the solution-focused approach. He was an English anthropologist, the son of the famous geneticist William Bateson, and was married to the famous anthropologist Margaret Mead. Bateson thought and wrote about systems theory and cybernetics (Bateson, 1972, 1979). One of his influences on the development of the solution-focused approach was his view that the social system in which people function is of great importance to the development and solution of problems. However, Bateson's greatest contribution to solution-focused therapy may well be that he started The Bateson Project (Cade, 2007). This was a communications research project in which researchers like John Weakland, Jay Haley, and William Fry observed and analyzed videotapes of famous therapists like Milton Erickson and Don Jackson. This project formed the basis of the Mental Research Institute and has enabled the work of Erickson to acquire a large audience and influence.

The Mental Research Institute

The *Mental Research Institute* (MRI) has played a vital role in the development of the solution-focused approach. At the MRI in Palo Alto, California, which was founded in 1958 by Don Jackson, researchers and therapists like Jay Haley, Paul Watzlawick, John Weakland, Richard Fisch, and Janet Beavin developed innovative approaches to therapy (Weakland, Fisch, Watzlawick, & Bodin, 1974). Within the MRI, Fisch, Weakland, and Watzlawick founded the Brief Therapy Center in 1966 (Cade, 2007). The therapists within this center developed a briefer, more goal-oriented and pragmatic approach to therapy. They viewed the person who came for therapy not as a patient but rather as a client or even a customer (Haley, 1976, 1980). They took what the client said very seriously, which meant that they focused on the problem that the client presented. Previously, it had primarily been the therapist who determined what the topic of the conversation should be. Further, the MRI therapists believed it was not necessary to talk extensively about the childhood of the client and about any underlying problem causes. They believed that the reasons for the current problems existed in the here-and-now and that solutions could be found in the present, too. Their logic was that if the client has a problem, he or she must be doing something wrong now: He or she must inadvertently do something which maintains the problem. The goal of therapy became to find out what the client does wrong and to convince him or her to stop doing this and to replace it with some other, more effective behavior.

The Birth of the Solution-Focused Approach

In the 1960s, *Insoo Kim Berg*, a young American therapist of Asian origin, was, like quite a few other therapists, was dissatisfied with the traditional way of doing therapy. She felt it did not work well. Looking back on this period in 2004, she said:

> I realized: "This doesn't work." And that was quite something! You must know, I had a typical Asian girl background: very obedient. I was sent to finishing high school in Korea, the type of school that teaches you to be a good housewife. And my mother's main mission had been to have me married into a nice family. It was quite a revolution that a girl like me could do something like that...be

> disobedient about how to do therapy. I knew I had to be disobedient quietly. I started reading a lot and I came across a text by Jay Haley called "The power tactics of Jesus Christ." Can you imagine that? This was a shock! I was shaken up. That was the beginning. That you could look at things like that! Then, I read his book, "Uncommon Therapy." And in the early seventies, I started to do things differently. And I really read a lot. For instance a book by Paul Watzlawick of MRI, The Mental Research Institute, in Palo Alto in California. Jay Haley, John Weakland, and Paul Watzlawick worked there. (Visser, 2004, para. 2-3)

Berg did not start working at the MRI but she did study there. John Weakland became a mentor to her. Incidentally, Weakland was also a mentor to *Steve de Shazer*, a creative person as well as a therapist. He had studied at the University of Wisconsin and had learned to play the saxophone at a professional level. He admired the work of Erickson. He was also an enthusiastic amateur cook. Around that time, de Shazer experimented a lot with the so-called one-way screen, a mirror through which a team of therapists could observe a therapy conversation without being seen by the client and the therapist. The purpose of using the one-way screen was to learn by observing conversations. At the end of the therapy session, the therapist went behind the mirror for a few minutes to talk with the team. The therapist would get feedback and tips from the team and would then go back to the client to give his feedback and tips and close the conversation.

In 1977, after Weakland had introduced Berg and de Shazer to each other at a MRI conference, they started working together. They spent lots of time together behind the screen and eventually became a couple. Berg convinced de Shazer to leave California and go with her to Milwaukee. The two of them and a few other therapists who were inspired by the MRI, like Jim Derks, Marilyn LaCourt, Eve Lipchik, Don Norum, and Elam Nunnally, worked there in a therapy practice called Family Service (Malinen, 2001). The majority of the therapists working at that organization were traditionally oriented, though. Berg remembered that she worked very hard and liked the challenge of accepting difficult cases other therapists would rather not take (Visser, 2004). Berg and de Shazer and their colleagues introduced the one-way screen in that organization to learn about effective therapy by closely observing what worked and to educate students. The students loved it but many of the traditional therapists objected to it. They thought using the one-way screen was unethical and pressured Berg and de Shazer to stop using it. At a certain point, the tension between the two camps became so intense that they and a few of their colleagues started their own practice.

The Brief Family Therapy Center

de Shazer and Berg started their practice in 1978 and called it the *Brief Family Therapy Center* (BFTC). Among the original members of the BFTC team were Steve de Shazer, Insoo Kim Berg, Jim Derks, Elam Nunnally, Eve Lipchik, and Marilyn LaCourt. Other therapists who became members of the team were Marvin Weiner, Alex Molnar, Wally Gingerich, Michele Weiner-Davis, John Walter, Kate Kowalski, Ron Kral, Gale Miller, Scott Miller, and Larry Hopwood (Cade, 2007; Visser, 2009, 2010). All these people contributed in one way or another to the development of the solution-focused approach. de Shazer and Berg and their colleagues had little money so they started in their own living room. Only later were they able to rent an office. Their mission was to find out what worked in therapy.

They did not want to take a specific theory as a starting point. Instead, they wanted to inductively build knowledge about what worked in therapy. They started by identifying traditional elements of therapy and removing one element at a time from sessions. Then they observed whether the client outcome had been affected by the removal of this element. They discovered that analyzing and diagnosing problems could be removed from the therapeutic conversation without negative consequences for client outcomes. In addition to the approach of systematically removing traditional elements of therapy, they did several other things, one of which was to actively study therapeutic "accidents" or spontaneous events in therapeutic conversations. When the therapist or the client did something that seemed to work, they discussed that and they tried it again. While trying to figure out what worked, they observed clients during actual conversations and videotaped conversations. They looked for interventions that helped clients to formulate more clearly what they wanted to achieve, that helped the client to become more confident in their possibilities, and that helped to identify ideas for steps forward. Each intervention that made clients become more aware of what they wanted to achieve, more optimistic, hopeful, energetic, and full of ideas was written down, discussed by the team, and used more often. As the model evolved, the client's voice became a more and more important criterion. Each time a client reported that some intervention had led to a positive change, they considered that intervention useful. They equated "what worked" with what the client found useful.[1]

It would be unfair to say that the team was only influenced by what happened in their conversations with clients. They were also influenced by what they read and by what other therapists were doing at the time. For instance, de Shazer meticulously studied the works of Wittgenstein (see, for instance, de Shazer et al., 2007, chapter 6) and therapeutic conversations between Milton Erickson and his clients. In addition, the team must have been influenced by social constructionist philosophy, which was popular at the time (see, for instance, Gergen, 1978). In addition, they were certainly influenced by the ideas of Bandler and Grinder (1975), developers of neuro-linguistic programming (see de Shazer, 1994, p. 18) and by the systemic approach to family

[1] The description in this paragraph of how the BFTC team found out about what worked in therapy was based on email exchanges with the following experts and solution-focused pioneers: Eve Lipchik, Wally Gingerich, Alasdair Macdonald, Brian Cade, Dan Gallagher, Gale Miller, Michelle Weiner-Davis, and Peter De Jong.

therapy by the Milan group (Selvini-Palazzoli, Boscolo, Cecchin, & Prata, 1978). What is not known is whether they were also influenced by—or were an influence on—the development of Appreciative Inquiry (an approach to organizational development), which also started to emerge in the 1980s and which resembles the solution-focused approach in that it also focuses on asking questions about when things were better (Cooperrider, 1986).

In addition to this, they did occasional quantitative studies to find out about the effectiveness of interventions (Weiner-Davis, de Shazer, & Gingerich, 1987), attempts to formalize the approach into an expert system[2], and several qualitative studies. They identified many interventions that often worked well, which helped them build a set of solution-focused tools. But they also made another important discovery: They learned that what worked well with one person would not necessarily work with the next person. This made them realize how important it was to pay close attention to how clients responded to whatever happened during the conversation and to use this. Between 1978 and 1985, the basis was created for what is now known as the solution-focused approach.

The Solution-Focused Approach in Writing

In those early years, the most prolific writer within the BFTC team was de Shazer. In 1982, he published his first book about the solution-focused approach, *Patterns of Brief Family Therapy: An Ecosystemic Approach* (de Shazer, 1982). At first, the therapy world did not receive de Shazer's ideas with great enthusiasm. He sent his article, *The Death of Resistance* (de Shazer, 1984), to a journal for the first time in 1979. It was rejected no fewer than 17 times before it finally was published in 1984 (Malinen, 2001). In the article, de Shazer claimed that it is a bad idea to think the client has resistance to treatment in therapy. According to him, what works better is to view therapy as a process of cooperation between therapist and client. He proposed that everything the client says or does can best be seen as an attempt to help the therapy process move forward. When the client said or did something the therapist did not understand right away, the therapist should not confront the client. Instead, the therapist should assume that the client had a good reason for saying or doing this. Approaching the client very constructively helped to build a good cooperation very quickly.

An important next publication was the article *Four Useful Interventions in Brief Therapy*, which he co-wrote with Alex Molnar (de Shazer & Molnar, 1984). In that article, one intervention they introduced was the *first session formula task*. This task, which the therapist gives to the client at the end of the first therapy session, goes like this:

> Between now and next time we meet, we (I) want you to observe, so that you can tell us (me) next time, what happens in your (life, marriage, family, or relationships) that you want to continue to have happen. (p. 298)

The invention of this intervention, which was later sometimes called *the continuation question*, formed an important step forward in the development of the solution-focused approach because it changed the orientation of the team drastically. From that moment, the members of the BFTC team started to focus more and more consciously on what already went well. Elam Nunnally, one of the original members, once said that the task was inspired by interventions used in paradoxical therapies (Malinen, 2001) in which clients were often discouraged to change anything.

As the title suggested, de Shazer and Molnar's (1984) article also contained three other interventions. The second intervention mentioned in the article was *do something different*. This task, which was inspired by the work of Gregory Bateson (1979), focused on replacing existing behavioral patterns with new ones. By trying out new behaviors, the client could encounter more effective patterns of behavior, which were solutions to his or her problems. The third intervention mentioned in the article was what was later called the *overcoming-the-urge task*:

> Pay attention to what you do when you overcome the temptation or urge to … (perform the symptom or some behavior associated with the complaint). (p. 302)

This intervention worked very well in helping clients avoid falling back into old, ineffective habits. Through this task, clients gradually became aware that they sometimes managed to resist their temptations successfully and how they did so. The task helped clients find ideas about how to overcome their urges.

The fourth intervention mentioned in the article was the *redefinition of stability as change* intervention. When the client said that he or she was stuck in a situation the therapist could respond by explaining that remaining stable in an increasingly difficult situation often requires many skills and that other people would perhaps have fallen back instead of remaining stable:

> A lot of people in your situation would have thought about suicide, which you wisely rejected as worse than useless, or they would have had an affair to get even, or they would have left him, or they would have yelled and screamed. But you chose the more difficult route, essentially pretending to remain unchanging as far as he's concerned. This course of action means that you've really had to change a lot in order to keep things appearing to be stable. A lot of people in your situation would have been unwilling to make this extreme sacrifice, and they would have thought that any change which impacted on him, any change which made him uncomfortable, might work to either end the affair or save the marriage

[2] Together with computer science graduate student Hannah Goodman, they did the BRIEFER project, Gingerich & de Shazer, 1991; see also Visser, 2010

> or both. Perhaps you need to stop changing so much, to be more rigid. Rather than continuing to change, maybe you need to pick something and stick to it. Then again, maybe you need to continue to sacrifice, continue to change. (de Shazer & Molnar, 1984, p. 303)

In his second book (de Shazer, 1985), *Keys to Solution in Brief Therapy*, de Shazer began to emphasize the importance of *creating an expectation of change*. He claimed that change was inevitable and he more and more began to use interventions that were based on this assumption. By asking questions that implied that change was certainly going to happen, the therapist contributed to the client's trust that the change was actually going to happen. An example of such a question is, "How *will* you know things *will* be better?' This formulation implies that change is going to happen more than this formulation: "How *would* you know things *could* be better?" The latter formulation is conditional; it leaves open whether the change is going to happen or not. In *Keys to Solution*, de Shazer for the first time explicitly claimed that detailed information about the complaint is not necessary for solving it. This book was also the first publication in which he explicitly wrote that past successes form a key to solving problems.

In 1986, de Shazer described the later famous technique of *the scaling question*, which the BFTC had been using for years, in the book chapter, *An indirect approach to brief therapy* (de Shazer & Kral, 1986). Scaling questions are the most flexible, simple, and popular techniques in the solution-focused toolkit. With scaling questions, the therapist asks the client to imagine a scale ranging from 0 to 10. The 10 position on the scale stands for the situation in which the problem has been solved and the desired state has been accomplished. The 0 position stands for the situation in which nothing has yet been achieved or in which the problem was at its worst. The therapist asks where the client is now on that scale and how he or she has managed to get from zero to the current position. When clients begin to answer this, they usually become more optimistic and hopeful and they find new ways to take further steps forward on the scale. The therapist may also ask what the highest point on the scale has been for the client and what was different then.

The technique of scaling questions emerged more or less by coincidence when a client, in a second session, answered a question from de Shazer about how things were: "I've almost reached 10 already!" de Shazer and his colleagues began to play with the use of scales and step by step, the scaling question was developed (Malinen, 2001).[3]

Around 1986-1987, new terms were added to the repertoire of the BFTC. For instance, the term *solution-focused* began to be used more often and more prominently. Also from this period stems the *what's better question* (de Shazer, 1986). This question is mainly asked at the beginning of the second and later sessions with a client. The advantage of this question is that the client can focus his or her attention fully on what progress he or she has made and on what has worked. This usually has a motivating effect, leads to more awareness of what works and to new ideas for steps forward.

In 1987, de Shazer mentioned the concept of *exceptions* for the first time in an article (Molnar & de Shazer, 1987). This concept refers to the fact that the intensity of problems always fluctuates. This means that there are always times when the problem is less severe or even absent for the client. These moments can be used to find keys to solve problems. Clients were encouraged to identify and analyze exceptions and to try to find out how they had managed to be less troubled at these moments. Then, they were encouraged to repeat what had worked well in these situations. Often, this helped in making exceptions occur more frequent and to last longer, and the problem slowly seemed to move to the background.

Weiner-Davis and colleagues (1987) carried out empirical research to find out what worked well in therapy. One of the surprising things they discovered was that the improvement of the client's situation had often started before the first conversation with the therapist. This appeared to be evident in roughly two-thirds of the cases. This phenomenon was labeled *pre-session change*. Clients themselves had started to make progress without the help of the therapist. Once this was known, solution-focused therapists used this fact by asking questions like: Which changes have already occurred since the moment you called me to make this appointment? Which things have helped since you called me? Which steps forward have you taken since you called me? What is better since you called me? In answering these questions, the client's self-confidence usually strengthened and solution-talk could proceed quickly.

Probably the most well-known and popular intervention within the solution-focused approach is *the miracle question* (de Shazer, 1988). Even many people who have never heard of the solution-focused approach have heard about the miracle question. Miller and Berg (1995) explained how the miracle question emerged when a client said that her problem was so serious that it would take a miracle to solve it. The therapist followed the client's suggestion and asked, "Well … suppose that happened.… What would be different?"

In his book, *Clues, Investigating Solutions in Brief Therapy,* de Shazer (1988) wrote about *the prediction task*. Prediction tasks are based on the idea that what you want to happen becomes more probable once the process that leads to it is set in motion. de Shazer had observed that simply predicting the desired change would increase the chance of it happening, no matter whether the prediction was positive or negative. In the same book, de Shazer described the difference between *visitors, complainers,* and *customers*. Visitors were clients who did not have a clear idea about what they wanted from the therapy. This could be the case, for instance, with involuntary clients. Complainers were

[3] Apparently, de Shazer was not aware of work done in the 1960s by psychologist Hadley Cantril, who developed an intervention which he called *The Cantril Self-Anchoring Striving Scale*, which can be seen as a true forerunner of the solution-focused scale.

clients who found it useful to talk with the therapist but who complained a lot and behaved helplessly. They usually did not see a clear relationship between their own behavior and the problem, let alone the solution. Customers were clients who found the conversation useful, were open to questions and suggestions by the therapist, and were prepared to do things to improve their situation. Customers could be given a so-called behavioral task, which could not be done with complainers, who could only be given so-called *observation tasks* (like the suggestion to pay attention to what was going right in their lives). A last well-known concept from the book, *Clues*, is *reframing.* This concept was included in the solution-focused model and was part of the brief therapy tradition since the 1960s (de Shazer, 1988; Mattila, 2001; Watzlawick, Weakland & Fisch, 1974). With reframing, apparently negative behaviors are placed in a positive light by focusing on the underlying good intentions and their possible usefulness in certain circumstances.

At least two concepts Eve Lipchik described in her publications have also become part of the arsenal of the solution-focused professional: *the coping question* and *listening with a constructive ear* (Lipchik, 1988). The coping question is the question, "How do you manage to go on?" This question is very useful when the client describes that his or her problems are severe, for instance, when they say they are at a zero on the scale. Listening with a constructive ear is related to the *Death of Resistance* idea (de Shazer, 1984). When listening with a constructive ear, you approach what the other says appreciatively and you notice good intentions and resources that would otherwise be harder to notice.

In his book, *Putting Difference to Work*, de Shazer (1991) emphasized, among other things, the development of *well-formed goals*. The idea is that specific goals are usually the starting point for change.

Harlene Anderson and Harry Goolishian (1992) wrote an article in which they asserted that it is helpful to the therapy process when the therapist assumes an *attitude of not-knowing*. This influential article elaborated the idea that therapists can never fully understand the situation of the client and never really know what is best for the client. Others proposed these kinds of ideas earlier. Erickson and Rossi (1979), for instance, mentioned the concept of not-knowing and even before that Don Norum, around 1978, wrote an article, which was not published then, but was known to the founders of the BFTC, called, *The Family Has the Solution*. This article may also have had some influence on the development of the solution-focused approach. The article was published many years later (Norum, 2000).

In the beginning of the 1990s, several other authors contributed to the development of the solution-focused approach. Three examples are Walter and Peller (1992), who wrote a great introduction to the solution-focused approach, Cantwell and Holmes (1994), who introduced the concept *leading from one step behind,* and Berg (1994), who described the use of *indirect compliments*.

Different members of the therapeutic team at the BFTC came and went over the years. Some of them later went on separate routes and others continued to define their work as part the SFBT model. Together with a number of co-authors, Berg described the model of solution-focused therapy in many therapeutic contexts (e.g., Berg, 1994; Berg & De Jong, 1996; Berg & Dolan, 2001; Berg & Kelly, 2000; Berg & Miller, 1992; Berg & Reuss, 1997; Berg & Steiner, 2003; De Jong & Berg, 2008). She also co-wrote several books illustrating how she supported the use of the solution-focused approach outside the context of therapy (e.g., Berg & Shilts, 2004; Berg & Szabó, 2005).

From the middle of the 1980s, the solution-focused approach was adopted and continually developed in Europe, America, Australia, and Asia by several teams and individual therapists. These teams and therapists worked both independently and in close contact with one another and exchanged their ideas and findings with each other. In these networks of teams and therapists that emerged, de Shazer and Berg were at the center. By the end of the 1990s, several individuals and groups from around the world also started to apply the solution-focused model outside the therapy context in coaching and organizational work. Berg and de Shazer, through their ongoing presence, teaching, and writing, were the people who provided consistency in the development and the continuing clarification of the solution-focused approach.

Conclusion

As leaders of BFTC, de Shazer and Berg played an exceptionally important role both in the development of the solution-focused approach and as ambassadors, spreading it across the globe. According to Berg (Kiser, 1995), de Shazer played a very creative and innovative role, while Berg, according to de Shazer, had a great impact, being a master therapist (Norman, McKergow, & Clarke, 1996). However, probably the most important factor was that with the BFTC there was both an atmosphere and practice of working together, which enabled every team member and several frequent visitors of the center to make their own contributions to the development of the solution-focused approach. Within a period of eight years, they laid the foundation for what would become a breakthrough in therapy and in coaching.

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Solution-Focused therapy is an increasingly popular approach, used by practitioners in a wide range of contexts and settings. Illustrating the breadth and depth of contemporary practice, the Handbook of Solution-Focused Therapy brings together contributions from leading practitioners in fields such as social work, education and health care to show how solution-focused techniques can be effective in many different situations. Beginning with an introduction to the origins and theory of the approach, the book examines different areas of practice, explaining how and why the solution-focused approa... Solution-focused brief therapy (SFBT) places focus on a person's present and future circumstances and goals rather than past experiences. In this goal-oriented therapy, the symptoms or issues bringing a person to therapy are typically not targeted. Instead, a qualified therapist encourages those in treatment to develop a vision of the future and offers support as they determine the skills, resources, and abilities needed to achieve that vision successfully. History and Development of SFBT. How Does SFBT Work? Techniques Used in SFBT. Issues Treated with SFBT. Pursuing Training in SFBT. Li