

# Solution-focused therapy

## *Counseling model for busy family physicians*

Gail Greenberg, MSW Keren Ganshorn, BPT, MD, CCFP Alanna Danilkewich, MD, CCFP, FCFP

### ABSTRACT

**OBJECTIVE** To provide family doctors in busy office practices with a model for counseling compatible with patient-centred medicine, including the techniques, strategies, and questions necessary for implementation.

**QUALITY OF EVIDENCE** The MEDLINE database was searched from 1984 to 1999 using the terms psychotherapy in family practice, brief therapy in family practice, solution-focused therapy, and brief psychotherapy. A total of 170 relevant articles were identified; 75 abstracts were retrieved and a similar number of articles read. Additional resources included seminal books on solution-focused therapy (SFT), bibliographies of salient articles, participation in workshops on SFT, and observation of SFT counseling sessions taped by leaders in the field.

**MAIN MESSAGE** Solution-focused therapy's concentration on collaborative identification and amplification of patient strengths is the foundation upon which solutions to an array of problems are built. Solution-focused therapy offers simplicity, practicality, and relative ease of application. From the perspective of a new learner, MECSTAT provides a framework that facilitates development of skills.

**CONCLUSION** Solution-focused therapy recognizes that, even in the bleakest of circumstances, an emphasis on individual strength is empowering. In recognizing patients as experts in self-care, family physicians support and accentuate patient-driven change, and in so doing, are freed from the hopelessness and burnout that can accompany misplaced feelings of responsibility.

### RÉSUMÉ

**OBJECTIF** Offrir aux médecins de famille dont la pratique en cabinet privé est surchargée un modèle de counseling compatible à la médecine centrée sur le patient, notamment des techniques, des stratégies et des questions nécessaires à sa mise en œuvre.

**QUALITÉ DES DONNÉES** Une recension a été effectuée dans la base de données MEDLINE de 1984 à 1999 à l'aide des mots clés « psychothérapie en pratique familiale, thérapie brève en pratique familiale, thérapie axée sur la recherche de solutions et psychothérapie brève ». On a identifié 170 articles pertinents; 75 résumés ont été cernés et un nombre à peu près égal d'articles ont été lus. Au nombre des sources d'information additionnelles figuraient des ouvrages fondamentaux sur la thérapie axée sur la recherche de solutions (TARS), les bibliographies des articles importants, la participation à des ateliers sur la TARS ainsi que l'observation de séances de ce genre de counseling enregistrées par des experts dans ce domaine.

**PRINCIPAL MESSAGE** La concentration des thérapies axées sur la recherche de solutions portent sur l'identification et l'amplification conjointes des forces du patient constitue le fondement sur lequel repose la détermination de solutions à un éventail de problèmes. La thérapie axée sur la recherche de solutions est simple, pratique et relativement facile à administrer. Du point de vue d'un néophyte, le MECSTAT offre les paramètres qui facilitent le perfectionnement des compétences à cet égard.

**CONCLUSION** La thérapie axée sur la recherche de solutions reconnaît que, même dans les circonstances les plus noires, l'insistance sur les forces du sujet se révèle habilitante. En reconnaissant les patients comme des experts pour prendre soin d'eux-mêmes, les médecins de famille soutiennent et accentuent les changements réalisés par le patient et, ce faisant, se libèrent de l'impuissance et de la fatigue professionnelle qui accompagnent parfois des sentiments mal placés de responsabilité.

*This article has been peer reviewed.*

*Cet article a fait l'objet d'une évaluation externe.*

*Can Fam Physician 2001;47:2289-2295.*

**C**ounseling has been the subject of numerous family medicine journal articles, focusing on a variety of issues.<sup>1-9</sup> All articles share one precept: family physicians are in the uniquely privileged position of working with patients who present with an array of physical and mental health concerns and problems.

As family physicians shift their delivery of patient care from a disease-centred to a patient-centred clinical method, the search for a compatible counseling paradigm is timely. Solution-focused therapy (SFT) emerged in the United States in the late 1970s and early 1980s under the umbrella of brief therapy. It was pioneered by family therapists who developed a model of counseling that clearly departed from the psychotherapeutic theory and practice of the day.<sup>10</sup>

The name of the new approach, SFT, captured its fundamental shift from a focus on problems to a focus on solutions. Counseling concentrated on solutions and on causes of problems, and conversations recognized clients as experts in solving their presenting problems. This idea, that “individuals have within them, or within their social systems, the resources to bring about the changes they need to make,”<sup>11</sup> is what makes SFT so compatible with patient-centred clinical care.<sup>11</sup>

The medical literature has begun to support SFT as a collaborative counseling model that fits within a busy patient-centred family practice.<sup>12-15</sup> Family physician advocates suggest that SFT’s concentration on patient strengths, abilities, and resources creates a counseling atmosphere flavoured with hope and optimism. It places responsibility for change in the hands of patients by using empowering language and recognizing them as skilled in matters of self-care. In this way it is deeply respectful of patients as individuals and takes a more balanced approach to finding solutions.

Use of basic counseling skills, such as attending and listening, genuineness, empathy, positive regard, and reflection, provide the foundation upon which SFT is practised. The model is applicable to the variety of mental and physical health problems in family medicine, and contraindications are minimal.<sup>11-15</sup> Giorlando and

*Ms Greenberg is Medical Education Coordinator,*

*Dr Ganshorn is an Assistant Professor, and*

*Dr Danilkewich is Residency Program Director and an Associate Professor in the Department of Family Medicine at the University of Saskatchewan in Saskatoon.*

*Ms Greenberg is a non-physician member and*

*Drs Ganshorn and Danilkewich are physician members of the Section of Teachers of Family Medicine in the College of Family Physicians of Canada.*

Schilling state that the approach allows the medical encounter to be effective, yet efficient, in terms of number and length of visits.<sup>12</sup> It is consistent with a busy practice where 15 minutes seems like a lot of time to have available for a counseling appointment.

### Quality of evidence

The MEDLINE database was searched from 1984 to 1999 using the terms psychotherapy in family practice, brief therapy in family practice, solution-focused therapy, and brief therapy. A total of 170 titles were identified. We decided to obtain abstracts when authors were physicians or nurses, the article title referred to a physical or mental health problem that presents in family medicine, the author was a recognized authority in SFT, or the title suggested an introductory or research focus. This left us with approximately 75 texts (articles, book chapters, and books) published over 10 years that were relevant to family practice.

Research on SFT’s effectiveness as a brief counseling model, though minimal, is promising.<sup>16-20</sup> It is important to state at the outset, however, that studies comparing short- to long-term therapies indicate negligible differences in outcome. In fact, de Shazer and Kim Berg<sup>21</sup> go so far as to suggest that “all therapy models work” because, by and large, individuals benefit from talking to a counselor.

Outcome studies indicate that between 66% and 80% of SFT clients improved during therapy. This indication supports 50 years of outcome studies<sup>22</sup> comparing psychotherapeutic approaches. Process studies evaluating specific SFT techniques suggest effectiveness, yet once again, the number of studies is small. When scientific research on SFT is rigorous, results consistently demonstrate it to be effective in assisting patients to accomplish their treatment goals.

### Assumptions of therapy

The following core assumptions are at the root of SFT and provide key ideas that drive the practice and techniques of this counseling model.<sup>11,23,24</sup>

- Change is constant, inevitable, and contagious. Solution-building conversations identify, elaborate, and reinforce change behaviour.
- Patients are experts on their lives. Our job is to support and amplify this expertise.
- Presuppositional language emphasizes the presumption that change *will* occur, creating an atmosphere of “when,” not “if.”
- Patients have strengths, resources, and coping skills that drive change while generating optimism and hope.

- Exceptions to the identified problem are often undervalued. Because exceptions are part of solution behaviour, solution-building conversations explore them in considerable detail.
- Extensive information about a problem is rarely necessary to bring about change.

### Overview of interview

The literature on SFT is abundant. We suggest the acronym, MECSTAT, conceived by and borrowed from Giorlando and Schilling,<sup>12</sup> as a good place to start for beginning practitioners of this model (we have slightly altered the acronym to reflect our own vision). The approach incorporates the fundamental and essential components and language of SFT, its nuts and bolts, and molds them into a model that is easy to both learn and use (Table 1). Although the literature on SFT is extensive, MECSTAT is the only documented model we found that clearly, succinctly, and sequentially walks counselors through the techniques of SFT.

**Table 1. Solution-focused therapy using MECSTAT**

<b>M</b>	Miracle questions
<b>E</b>	Exception questions
<b>C</b>	Coping questions
<b>S</b>	Scaling questions
<b>T</b>	Time-out
<b>A</b>	Accolades
<b>T</b>	Task

The model captures the essence of SFT. In any given encounter with a patient, a physician can combine the steps depending on time available, the problem, the patient's readiness to change, and the physician's emerging skill level and comfort with various techniques. Each visit ends with assigning a task that keeps patients focused on solution building.

Posing miracle, exception, coping, and scaling questions are central to solution-building conversations (Table 2).<sup>25-28</sup> By asking these questions, we remind patients of many things: change is constant; exceptions to problems exist; coping indicates strength; goals that are important to and defined by patients help drive and sustain change; and change, commitment to change, and the confidence that change will occur is measurable in increments.

**Table 2. Miracle question: Variations on a theme**

Imagine that, while you are sleeping tonight, a miracle happens. You wake up tomorrow, and you sense that you are on track toward making a decision. What will you be doing differently that will tell you that you are on track?

Imagine 6 months into the future, after you have successfully solved the problem that brings you here today. What will be different in your life that will tell you the problem is solved?

Pretend the problem is solved. What are you doing differently?

If I have a video camera and follow you around when you have solved this problem, what will I see that will tell me this?

What will be the first sign that a piece of the miracle is happening?

- Who will be the first to notice this is happening?
- What will others notice about you that will tell them this is happening?

Questions are asked using presuppositional language. Inherent in any question is the presumption that change is inevitable and probably already happening. Use of the word "suppose" implies that the patient knows the answer and, if not, encourages imagining an alternative. "When you are on track to solving the problem that brought you in today," elicits problem-solving skills and suggests that the problem will be resolved. Additional examples of presuppositional language include asking "instead of" questions ("What will you be doing *instead of* crying?"), "difference" questions that explore exceptions and reinforce change ("What will your spouse notice you are doing *differently* when you are coping better with the pain?"), and the use of tentative speech suggesting change ("Could it be that you are already on track to deal with the drinking problem?").

### Miracle questions

After meeting with patients and getting a brief description of presenting problems, posing the miracle question signals the onset of solution talk.<sup>29</sup> This question and all related amplification questions help patients identify a goal, something that will be improved or different to signal that treatment has been successful. Because SFT is goal oriented, miracle and related questions facilitate description of a goal that indicates the presence of something different, rather than an absence, something that is concrete, in the present, in patients' language and control, and indicative of beginnings.

Although there are variations of the miracle question, we suggest that a good place to begin is with the following: "I am going to ask you a question that

**CME**  
.....

**Solution-focused therapy**

Ejemplo  
Pregunta  
milagro

is different from those you might have heard before. It is going to require that you do some pretending. Suppose that tonight, after our meeting, you go home, go to bed, and fall asleep. While you are sleeping, a miracle happens, and the miracle is that the problem that brought you here is solved. But, because you are asleep, you do not know that the miracle has happened. When you wake up tomorrow morning, what will be the first thing you notice that will tell you the miracle has happened?" (Table 2).

This question encourages patients to construct a vision of the future. All related questions serve to amplify the description, providing details of what the "solution picture" will look like. Merely posing the miracle question appears to act as a catalyst for people on the cusp of making changes. As with all the other components of MECSTAT, asking the miracle question and then subsequent questions can be a stand-alone intervention (also called a single-step strategy). Because it elicits and amplifies patient goals, the miracle question is the place to begin.

Usually, we ask a pre-session change question before the miracle question; often a small piece of the miracle (the goal) happens between the time an individual books an appointment and then comes in to the office. "Many times, in between the call for an appointment and the appointment, people notice that already things seem different. What have you noticed about your situation?" This question focuses on differences and signals to patients an intention to draw on strengths and resources.

**Exception questions**

These questions are intended to uncover patients' successes and strengths. Exception questions operate from the presumption that there are always times when the identified problem is less intense or absent and when pieces of the desired solution picture appear. Patients often paint a problem picture that is universally present, and exception questions short-circuit this presentation by eliciting exception behaviour, instances when the desired outcome is happening, "even if only a little bit." Once patients identify exceptions, physicians amplify their role in the solution picture<sup>30</sup> (Table 3).

**Coping questions**

Hopelessness is often expressed by patients in the grip of crises or chronic problems, and it behooves physicians to rise above it. Coping questions enable both patients and physicians, particularly in situations that seem overwhelmingly hopeless, to

---

**Table 3. Exception questions**

---

Are there times now that a little piece of the miracle happens? Tell me about these times. How do you get that to happen?

What will you do to make that happen again?

What will your husband (for example) say you need to do to increase the likelihood of that (exception) happening more often?

What is different about the times when the problem does not happen, or when it is less severe or less frequent?

---

**Table 4. Coping questions**

---

How did you manage to get yourself up this morning?

How are you preventing things from getting worse?

That sounds nearly overwhelming. How do you manage to cope?

I understand how hard this is for you. How did you manage to get to the office today?

---

accept patients' perceptions of their situations, and then highlight how patients cope with and endure difficulty<sup>31-33</sup> (Table 4). These kinds of questions uncover concrete acts taken by people coping with adversity and provide a foundation upon which to build solutions.

**Scaling questions**

Scaling questions are useful for making vague patient perceptions concrete and definable. They measure problem severity, progress toward a goal, confidence, and commitment to a goal.<sup>28</sup> On a 10-point scale, the number 10 represents the most positive end of the scale. Asking a patient to "scale" items transforms a description of something important into an accessible and measurable entity. This then becomes a starting point from which future progress can be assessed (Table 5).

---

**Table 5. Scaling questions**

---

On a scale of 1 to 10, where 10 is the problem solved and 1 is the worst it has ever been, where is the problem today?

On a scale of 1 to 10, with 10 meaning you have every confidence this problem can be solved and 1 meaning no confidence at all, where are you today?

If 10 means you are prepared to do anything to find a solution and 0 means that you are prepared to do nothing, how would you rate yourself today?

What will you need to do to go from a (for example) 3 to a 3.5?

If a patient scales a problem at 1 or 2, you might ask, "How will you know when you reach 2.5?" This question requires the patient to identify the next step and to begin solving the problem. If confidence is scaled at 1, asking, "How did you manage to come in today?" encourages a patient to recognize that action is possible even with low confidence. If confidence is scaled at 3, a question like, "What do you need to do in order for your confidence to move to 3.5?" will encourage thinking in concrete terms of strategies needed to sustain and increase confidence. When patients have trouble thinking in terms of forward movement, a question like, "What do you need to do to maintain the progress at 3?" frees up both patients and physicians to recognize that sometimes, treading water is an accomplishment in and of itself.

### Time-out

Because SFT is a counseling model used by a variety of health care professionals, using time-out is practical for some and not for others. Time-out allows both clients and counselors to reflect on conversations they have just concluded. When a session has been observed by colleagues behind a one-way mirror, counselors use the time-out for consultation. At the onset of each session, counselors inform clients that a time-out will occur toward the end of their time together that day. This time-out prepares clients to receive the accolades and task assignment that follow.

Family physicians should limit time-outs to a minute or two, during which time physicians leave the examining room to mentally list the accolades to deliver moments later. Although time-outs are not always feasible, the rationale for using them warrants reinforcement: the accolades we offer patients are part of solution talk, and taking a minute or two to identify praise statements is important.

### Accolades

Using accolades is a simple strategy that packs a powerful punch. Integral to solution-building conversations, its effect is multiple: it validates any progress that patients make; it encourages patients by reminding them of personal power over their well-being; it emphasizes strengths and abilities; it sets up the expectation that past success is an excellent indicator of future possibilities; it fosters confidence; and it facilitates relationship building and maintains rapport.<sup>29</sup>

Accolades take many forms, including compliments and cheerleading. Simple statements are intended to reflect back to patients positive observations about something they have said or done. When accolades

take the form of cheerleading, they encourage patients to think aloud about personal accomplishments. "How did you decide to do that?" or "How do you explain that?" reinforces and accentuates exception behaviour.

In reality, once you get your head around the power behind the use of accolades, it becomes, for some of us, the easiest and most supportive first step in solution talk. When we focus on small things patients do to overcome adversity, we quickly begin to notice strengths and accomplishments. These become the subject of compliments.

### Task

Assessing patients' change readiness in terms of the cycle of change by Prochaska et al<sup>34</sup> influences the negotiated task. Webster summarizes it quite nicely:

Clients who are very unsure about what they want from therapy are usually not given assignments. Those who have a defined complaint are given the task to observe when exceptions occur. Clients who are willing to change are given "doing" tasks, which amplify existing exceptions and construct different kinds of interactions in their real life.<sup>35</sup>

The homework task is discussed at the end of the session, after the time-out. As physicians begin to learn to use this model, we suggest the following as possible generic assignments to negotiate with patients: think about the times when an exception occurs and note differences; observe for positive changes; do more of the exceptions and pay attention to the consequences; pretend to do a small piece of the miracle picture; pretend you know what to do to start solving the problem and try it out; and finally, think about what you are doing to prevent the situation from worsening.<sup>36</sup>

### Benefits and caveats

Shifting from one's favourite counseling approach to one that is new and unfamiliar is not without peril. We have experienced first-hand the dissonance from such an endeavour. The benefits of using this approach, however, far outweigh the discomfort of a counseling situation when we are barely one step ahead of patients in our own knowledge and experience.

Solution-focused therapy is easily integrated into patient-centred clinical care. Its language is both hopeful and optimistic. Appreciating that change occurs in small increments means that goal behaviour is readily accessible and attainable, thus creating a positive climate for both patients and physicians. Solution-focused therapy puts ownership of their health back

## CME

.....

### Solution-focused therapy

into the hands of patients, and in so doing reminds them of the control, authority, and responsibility they have over their lives. This feels good to patients and doctors alike. It relieves physicians of the silent burden of having to come up with the right answers, while providing tools to find answers.

Ample literature supports using SFT with patients in a variety of situations: psychiatric disorders, sexual abuse, grief, palliative care, family dysfunction, weight loss, addictions, and physical disability, to name a few.<sup>26,28-33</sup> It is important to clarify, however, that SFT is different from long-term, traditional counseling approaches in its assumption that patients are capable of moving forward and growing in spite of incomplete understanding, insight, or resolution of deep, underlying problems. Although these problems are not denied, patients determine the pace of discovery and relevance to the current solution.

Contraindications are minimal, and can generally be described as any situation where counseling in family physicians' offices is contraindicated: emergencies, life-threatening situations, threats of suicide, or psychotic episodes. Time restraints of family practice often mean that physicians learning to use the model take a "single step" approach. We encourage learners to select bits and pieces of the acronym MECSTAT, become familiar with its language and method of asking questions, and then gradually build on as comfort with the model grows. Quite often, scaling is a good place for new learners to get their feet wet (for example, scaling "coping" and "hope" in a patient with depression). On the 10-point scale, scaled information provides a small goal to work on between appointments (patients could choose to maintain hopefulness at a particular number as a week's goal, or perhaps pay attention to coping behaviour).

The biggest hurdle in implementing the model lies in initially trying to do too much, given time and knowledge constraints, which can be very frustrating. Solution-focused therapy as a conceptual model is user-friendly, and steps can be taken one at a time. We like keeping visual reminders in the room with us during practice sessions, reminding us what to do when clinical encounters begin to sound like problem talk instead of solution talk. We encourage new learners to read SFT material (the reading will help address various dilemmas, such as when patients present the solution in terms of changes in another's behaviour, or of the absence of something). Do a little, monitor SFT attempts in patient charts, follow up with SFT strategies, and practise, practise, practise!

### Editor's key points

- Solution-focused therapy is a practical method of counseling for busy family physicians that is both efficient and effective.
- Solution-focused therapy is based on assumptions that change is inevitable, that patients are experts on their own lives, that patients have strengths and resources, and that they can be supported to find their own solutions.
- Solution-focused therapy is patient-centred and expresses optimism that problems can be solved.

### Points de repère du rédacteur

- La thérapie axée sur la recherche de solutions représente un mode pratique de counseling pour les médecins de famille affairés, qui est à la fois efficiente et efficace.
- Cette thérapie se fonde sur l'hypothèse que le changement est inévitable, que les patients sont les experts quant il s'agit de leur propre vie, qu'ils ont des forces et des ressources, et qu'ils peuvent être appuyés dans la recherche de leurs propres solutions.
- La thérapie axée sur la recherche de solutions est centrée sur le patient et est empreinte d'optimisme quant à la résolution des problèmes.

### Conclusion

Solution-focused therapy is a brief counseling model that seems uniquely adaptable to patient-centred care. The MECSTAT acronym offers a ready-to-use tool that captures the essence of the model and provides a step-by-step guide for new learners. Best of all, physicians who have used SFT describe its optimism and hopefulness with patients whose lives sometimes seem bleak. This counseling model offers both patients and physicians a new way to discuss the intricacies of life that is refreshing, effective, and filled with promise and change. ❁

### Competing interests

None declared

**Correspondence to:** Ms Gail Greenberg, Regina General Hospital, 1440—14th Ave, Regina, SK S4P 0W5; fax (306) 766-4041; e-mail [ggreenberg@shin.sk.ca](mailto:ggreenberg@shin.sk.ca)

### References

1. Borins M, Morris BAP. Role of family physicians in counseling and psychotherapy. *Can Fam Physician* 1995;41:757-8 (Eng), 769-71 (Fr).
2. Williamson P. Psychotherapy by family physicians. *Prim Care* 1987;14:803-16.
3. Swanson JG. Family physicians' approach to psychotherapy and counseling. Perceptions and practices. *Can Fam Physician* 1994;40:53-8.

4. Blattel RA. Adverse effects of psychotherapy in family practice [case report]. *Can Fam Physician* 1992;38:663-4,734.
5. Christie-Seely J. Counseling tips, techniques, and caveats. *Can Fam Physician* 1995;41:817-25.
6. Peterkin AD, Dworkind M. Comparing psychotherapies for primary care. *Can Fam Physician* 1991;37:719-25.
7. Rosser WW, Borins M, Audef D. Anxiety disorders in family practice. Diagnosis and management. *Can Fam Physician* 1994;40:81-8.
8. Rockman P, Moran B. *An introduction to brief therapy for family physicians*. Toronto, Ont: Rockman and Moran; 1997.
9. Links PS, Balchand K, Dawe I, Watson WJ. Preventing recurrent suicidal behaviour. *Can Fam Physician* 1999;45:2656-60.
10. Barker P. Solution-focused therapies. *Nurs Times* 1998;94:53-6.
11. Chandler M, Mason W. Solution-focused therapy: an alternative approach to additions nursing. *Perspect Psychiatr Care* 1995;31(1):8-13.
12. Giorlando M, Schilling R. On becoming a solution-focused physician: the MED-STAT acronym. *Fam Systems Health* 1997;4:361-72.
13. Poon VHK. Short counseling techniques for busy family doctors. *Can Fam Physician* 1997;43:705-13.
14. McNeilly R. Solution oriented counseling: a 20-minute format for medical practice. *Aust Fam Physician* 1994;23:228-30.
15. Park E. An application of brief therapy to family medicine. *Contemp Fam Ther* 1997;19:81-8.
16. Franklin C, Corcoran J, Nowicki J, Streeter C. Using client self-anchored scales to measure outcomes in solution-focused therapy. *J Systemic Ther* 1997;16:246-65.
17. Macdonald A. Brief therapy in adult psychiatry—further outcomes. *Assoc Fam Ther Systemic Pract* 1997;19:213-22.
18. Jordan K, Quinn WH. Session two outcome of the formula first session task in problem- and solution-focused approaches. *Am J Fam Ther* 1994;2(1):3-16.
19. Zimmerman T, Layne A, Wetzell B. Solution-focused couple therapy groups: an empirical study. *Assoc Fam Ther Systemic Pract* 1997;19:124-44.
20. Steenbarger B. Toward science-practice integration in brief counseling and therapy. *Counseling Psychol* 1992;20(3):403-50.
21. De Shazer S, Kim Berg I. 'What works?' Remarks on research aspects of solution-focused brief therapy. *Assoc Fam Ther Systemic Pract* 1997;9:121-4.
22. McKeel AJ. A clinician's guide to research on solution-focused brief therapy. In: Miller S, Hubble M, Duncan B, editors. *Handbook of solution-focused therapy*. San Francisco, Calif: Jossey-Bass Publishers; 1996. p. 251-71.
23. Hillyer D. Solution-oriented questions: an analysis of a key intervention in solution-focused therapy. *J Am Psychiatr Nurs Assoc* 1996;2(1):3-10.
24. Walter J, Peller J. Rethinking our assumptions: assuming anew in a postmodern world. In: Miller S, Hubble M, Duncan B, editors. *Handbook of solution-focused brief therapy*. San Francisco, Calif: Jossey-Bass Publishers; 1996. p. 9-26.
25. Furman B, Ahola T. Solution talk: the solution-oriented way of talking about problems. In: Hoyt M, editor. *Constructive therapies*. New York, NY: The Guilford Press; 1994. p. 41-66.
26. Miller SD. Some questions (not answers) for the brief treatment of people with drug and alcohol problems. In: Hoyt M, editor. *Constructive therapies*. New York, NY: The Guilford Press; 1994. p. 92-110.
27. DeJong P, Miller S. How to interview for client strengths. *Soc Work* 1995;40(6):729-36.
28. DeJong P, Kim Berg I. *Interviewing for solutions*. Pacific Grove, Calif: Brooks/Cole Publishing Company; 1998.
29. Walter J, Peller J. *Becoming solution-focused in brief therapy*. New York, NY: Brunner/Mazel, Inc; 1992.
30. Hopwood L, Taylor M. Solution-focused brief therapy for chronic problems. In: Vandecreek L, Knapp S, Jackson T, editors. *Innovations in clinical practice: a source book*. Vol 12. Sarasota, Fla: Professional Resource Press, 1993. p. 85-97.
31. Butler W, Powers K. Solution-focused grief therapy. In: Miller S, Hubble M, Duncan B, editors. *Handbook of solution-focused brief therapy*. San Francisco, Calif: Jossey-Bass Publishers; 1996. p. 228-47.
32. Duvall J, Rockman P. Living a wonderful life: a conversation with Yvonne Dolan. *J Systemic Ther* 1996;15:82-93.
33. Ahlers C. Solution-oriented therapy for professionals working with physically impaired clients. *J Strategic Systemic Ther* 1992;11(3):53-68.
34. Prochaska JO, DiClemente CC, Norcross JC. In search of how people change: applications to addictive behaviors. *Am Psychol* 1992;47(9):1102-14.
35. Webster D. Solution-focused approaches in psychiatric/mental health nursing. *Perspect Psychiatr Care* 1990;26(4):17-21.
36. Cade B, O'Hanlon WH. *A brief guide to brief therapy*. New York, NY: W.W. Norton & Co; 1993.