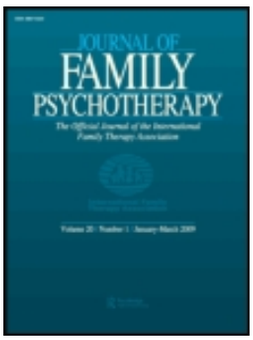

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Solution-Building, the Foundation of Solution-Focused Brief Therapy: A Qualitative Delphi Study

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ABSTRACT

The term solution-building has been used in numerous solution-focused brief therapy books and peer reviewed journal articles with differing definitions and descriptions for what this term means. The current qualitative Delphi study sought to clearly identify what solution-building is and what it means to the practice of solution-focused brief therapy. The results were gathered by conducting 3 rounds of qualitative surveys with 42 solution-focused brief therapy experts from around the globe. The results of these surveys, including a definition of solution-building, a description of the clinician's role and the client's role in this process, and a description of how solution-building and problem-solving differ are outlined. The clinical and training implications of these results are discussed.

KEYWORDS

Delphi study; problem-solving; solution-building; solution-focused brief therapy (SFBT)

Introduction

Since the late 1970s, solution-focused brief therapy (SFBT) has grown in popularity among psychotherapists that work in the fields of counseling, marriage and family therapy, and social work, among others. SFBT is a pragmatic approach to working with people that focuses on moving toward a desired future (de Shazer et al., 2007). This means that the practitioner does not necessarily need to know much information, if any, about the problem that led the client(s) into therapy (de Shazer et al., 2007). This also means that the clinician does not usually need to explore such problems in detail. Due to this stance, practitioners utilizing other approaches have criticized SFBT as too simplistic and dismissive of client problems. However, proponents of SFBT advocate that the simplicity of the approach is actually a strength which helps the clinician stay true to the client's goals and enables them to build unique solutions with each client. The solution-focused approach has built a research base in many arenas and with various populations including schools, group therapy, substance abuse, businesses, and individual psychotherapy, and has been shown to be an effective, evidence-based approach to treat a number of different problems (Franklin, Trepper,

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Gingerich, & McCollum, 2012; Gingerich & Peterson, 2013; Kim, 2008; Macdonald, 2007; Stams, Dekovic, Buist, & de Vries, 2006).

SFBT

SFBT was developed by Steve de Shazer, Insoo Kim Berg, and a team of practitioners at the Brief Family Therapy Center in Milwaukee, Wisconsin. (De Jong & Berg, 2013). SFBT is a pragmatic approach with a strength-based stance to working with clients based on the belief that the client is the expert on his/her own life. The therapist assumes responsibility for the process of therapy and guides the client(s) through this process as a collaborative partner in co-constructing a new language reality (de Shazer et al., 2007). The model is focused on discovering times when the client is not experiencing negative symptoms and focuses on identifying positive aspects within the client's life. These positive and future-focused aspects are viewed as potential pathways toward lasting solutions. These exception times are amplified through the co-constructed therapeutic process that results in a short-term intervention that is aimed at resolving issues in client's lives (Smock et al., 2008). Due to the short-term nature of this solution-building approach it has become attractive in many different settings for clinicians and in recent years the evidence-base of SFBT has grown (Corcoran & Pillai, 2009; Franklin et al., 2012).

Solution-building

De Jong and Berg (2013) provide a description of solution-building and the process of working with clients in this way. They outline that the solution-building process is developed through the following stages, (1) describing the problem, (2) developing well-formed goals, (3) exploring exceptions, (4) end-of-session feedback, and (5) evaluating client progress. De Jong and Berg also outline that solution-building is different from problem-solving in that the nature of the problem is not examined; instead client resources and strengths are used to empower clients to resolve the problem that led them into therapy.

The solution-building process has also been described in its application to couple's therapy. Connie (2012) also, describes solution-building as a stage process that involves building on the couple's conjoined strengths and using language to amplify the couple's use of the strengths in their daily lives. Connie also asserts that the solution-building process is different from the problem-solving process; solution-building clinician focuses the conversation on what the couple desire for their future and what strengths and resources can be used to make that future a reality, rather than brainstorming what specific solution may remediate the stated problem.

Despite these clinical descriptions of solution-building, only one empirical study, by Smock, McCollum, and Stevenson (2010) has been conducted to delineate the components of solution-building. Smock et al. (2010) statistically evaluated three components of solution-building, (1) client's clear identification of a solution/goal, (2) an increase in client's awareness of exceptions to the problem, and (3) the client developing hope in the future. Smock et al. (2010) concluded that individual components of solution-building were not supported statistically, but rather that solution-building is a single construct. It is unclear from this research if this empirical concept of solution-building is consistent with the process conceptualization outlined in the clinical writings. It is imperative, in an era with a growing emphasis on evidence-based practices and "best-practices," that clinicians and clients know and understand what is happening within their therapeutic encounters and that what is being done is effective and useful. In order to evaluate the solution-building process more thoroughly, a more clear definition and an outline of the solution-building process are needed.

Given this lack of empirical research and uniform understanding of solution-building, even within the SFBT community, these authors sought to answer the following questions, (1) What is solution-building?; and (2) How does a clinician solution-build with his/her client(s)?

Method

To answer the research questions the authors conducted a qualitative Delphi study. The purpose of a Delphi study is to, "achiev[e] convergence of opinion concerning real-world knowledge solicited from experts within certain topic areas" (Hsu & Sandford, 2007, p. 1). In this case SFBT experts participated in a qualitative description of what solution-building is and how it is done within therapeutic settings. The Delphi methodology was selected in order to pool the collective knowledge of SFBT clinicians who are actively and currently contributing to SFBT research and/or teaching and training future SFBT professionals to work from a SFBT perspective.

Participants

Participants were recruited through a recruitment script which was sent electronically via two methods. First, the authors sent an e-mail to the personal e-mail addresses of conference attendees from three conferences; the 2011 conference on Solution-Focused Practices Through the Solution-Focused Brief Therapy Association in North America (Bakersfield, CA), the 2010 Conference of the European Brief Therapy Association (Malmo, Sweden), and the First Solution-Focused World Conference (2008; Aruba). Additionally, the recruitment script was posted to a SFBT worldwide listserv.

The recruitment script instructed interested/qualified participants to send contact information to either of the authors and requested that the research announcement be forwarded to other potential participants who did not receive the e-mail or who were not on the listserv.

The recruitment script included a list of three inclusion criteria for expert participants. Participants were required to meet at least two of the following three expert criteria: (1) Must have authored or co-authored at least two peer reviewed articles, book chapters, or books in the last 5 years with content that is related to SFBT; (2) Must have conducted at least three workshops, trainings, or presentations at national/international conferences in the last 5 years with content that was related to SFBT; and (3) Must currently hold a training or education position (i.e., program director, professor, training supervisor, etc.) that leads participants/students to certification or degree with related SFBT curriculum. These criteria were selected to ensure not only expertise in SFBT, based on peer-reviewed involvement in the field, but also currency of contributions to an ever-evolving field.

Initially, 44 individuals responded to the recruitment script and submitted detailed listings of their qualifications. The researchers reviewed the qualifications and determined that 42 individuals qualified for inclusion in the study. The final 42 participants included 23 (54.8%) men and 19 (45.2%) women from 12 different countries and four continents (Asia, Australia/Oceania, Europe, and North America). Collectively the group reported being the authors of at least 51 books, 55 book chapters, and 53 peer-reviewed journal articles, having conducted nearly 600 presentations and/or trainings, and holding the following education/training positions: lecturer, diploma program coordinator, program director, certificate program contributor, adjunct instructor, educator/trainer, post-graduate program director, managing director, director of certificate program, head-of-center for trainers, CEO, founding member of teaching institute, and supervisor. One note about publications and presentation numbers; these may be slightly inflated. These numbers reflect each individual's contributions, therefore, if multiple participants co-authored or co-presented a single presentation/publication, this presentation or publication may be reflected more than once in these numbers. Despite this possible inflation, these participants have been some of the major contributors to the information available on SFBT.

Procedures

As previously noted, participants responded to the recruitment request by sending contact information (an e-mail address) to be used for the study, to one or both of the authors. Forty-two participants self-selected and qualified to participate in this study. Participants were asked to complete three separate rounds of electronic questionnaires through survey monkey. During all

Table 1. Response rates.

Round	Response rate
Round 1	35/42 (83.3%)
Round 2	33/42 (78.6%)
Round 3	29/42 (69.0%)

three rounds, participants were asked not to provide any identifying information and, therefore, all responses were anonymous and could not be linked back to any given individual. It was anticipated that this would allow respondents the ability to disagree with the group consensus without being identified or outted to the researchers or others within the SFBT community.

When participants were sent the first set of questions the researchers had the following goals: (1) gain a basic understanding of what solution-building is; (2) gain an understanding of how SFBT clinicians solution build; and (3) gain an understanding of the similarities and differences between solution-building and problem-solving. Participants had 2 weeks to respond to this round of questions (see Table 1 for response rates).

Upon receiving the responses, the researchers took 4 weeks to analyze the data and to inductively develop the next set of questions (questions are available from the first author upon request). The researchers utilized traditional qualitative analysis techniques outlined by Strauss and Corbin (1998) and the analysis occurred through three steps. During step one, both researchers began by independently open-coding the responses to identify common themes or dimensions within the responses (Strauss & Corbin, 1998). Once general themes were identified and the researchers agreed (through inter-rater reliability check), the researchers began step 2. Each researcher re-analyzed the data individually through axial coding (identification of sub-themes) and then inter-rater reliability was evaluated a second time. Throughout both of these steps of analysis, each researcher kept field notes regarding how themes were created, important components to be included in a definition of solution-building, as well as ideas for the development of survey questions for the subsequent rounds of data collection. Finally, in step three of the data analysis, the researchers developed the questions to be included as part of the next round of data collection.

Round 2 and Round 3 procedures followed the steps outlined above; however, no new questions were developed during the Round 3 analysis. The researchers' goals for Round 2 were, (1) refine a beginning definition of solution-building developed from Round 1 responses; (2) clarify points of disagreement between participants' responses; (3) gather greater consensus among the group, if possible; and (4) discover aspects of solution-building that were initially overlooked by the researchers. The researchers goals for Round 3 were, (1) continue to refine the solution-building definition; (2) gain feedback

about minor aspects of solution-building that were raised by individual participants (i.e., therapeutic alliance, emotion, and types of communication); and (3) gain insight into ideas for future directions for solution-building research. The entire data collection and analysis process took approximately 4 months.

Results

The results from the collective qualitative questionnaires will be outlined in the following format, (1) a proposed definition of solution-building in therapy; (2) the clinician's role in the solution-building process; (3) the client(s)' role in the process; (4) a description of the differences between problem-solving and solution-building; and finally (5) a description of some minor points of disagreement about the solution-building process among the participants. Given that the purpose of a Delphi study is to create a consensus, the responses endorsed by the majority of participants will be outlined in detail. After the majority responses are outline some discussion will be provided that outlines minor areas of disagreement.

Solution-building definition

Solution-building can be defined as, "a collaborative language process between the client(s) and the therapist that develops a detailed description of the client(s)' preferred future/goals and identifies exceptions and past successes." Although this definition is sufficient, further delineation, based on participants' responses, will be useful in clarifying this complex process.

Solution-building is the central and key component of SFBT. Solution-building is a process that differs from problem-solving and which can be viewed as beginning (although somewhat informally) at various stages of the therapeutic relationship, and is seen as a progressive process, meaning it builds over time. The general process of building solutions is generally initiated by the client and maintained by both the client and the clinician. Many SFBT clinicians consider the process of building solutions starting when the client begins to think about making a change and/or contacts the clinician for services. However, the collaborative process of solution-building (observable language process) officially begins when the client and clinician meet for the first time (either in person or by phone). This relationship is formalized during the first spoken words within the session. The therapist fosters this collaborative process by taking a "curious," "warm," and "accepting stance" and by beginning the session by asking about "best hopes" or what the client would like to get out of the session (this may also be known as the goal or destination of therapy). Solution-building then develops through the ongoing, *building* language of the client and the clinician.

Solution-building is language

Formally, solution-building takes place at the language level. The therapist formulates responses/questions by using the client's words from previous statements and highlights or punctuates the positive/hopeful language of the client (this process will be outlined in more detail in the *Clinician's Role* section below). The clinician knows that the process is working when the conversation does not become problem saturated, but rather the client develops a different perspective or new ideas. This success is evidenced by the client's language beginning to shift (e.g., "providing examples of when things went right," "focusing on their own sense of control rather than helplessness," and/or "noticing the positives in situations" [i.e., exceptions]). This shift can be noticed within a single session or over the course of multiple sessions. Often times clinicians may notice clients "moving up the scale" as an indication that the solution-building process is being effective; however, scaling questions were not specifically mentioned as necessary within the solution-building process. This gradual improvement process focuses on desired changes that increase in the client's life rather than brain-storming how to solve a particular problem.

Most of the SFBT expert professionals considered emotions and non-verbal communication (i.e., gestures, facial expressions, etc.) as part of the overall communication between the client and the clinician. Many experts emphasized that these components of communication need to be attended to by SFBT practitioners and incorporated within the solution-building process. This incorporation, like all aspects of solution-building, will occur at the language level. Therefore, a clinician who is solution-building with their client(s) will use the "emotional" language and experiences of their clients to develop the preferred future rather than commenting overtly on the emotion that may be visible within the session. One respondent wrote,

> "[Emotion] is not something I will specifically ask about. I find that client's emotions will be triggered naturally when you're dealing with personal and sensitive issues. Often they will cry or laugh as a natural process in our work. I might ask how their thinking, feeling[s] or behavior might change or be affected as a result of the change they are experiencing or deciding to do."

Another respondent reply,

> "If someone talks about wanting to feel a certain way, exploring what would be happening or what they and others would be doing can be built upon it. I think asking 'how do you want to feel?' adds a sensory element when you are developing a rich description but also can help people to make distinctions about what they want or feel they ought to be thinking about."

Similarly, a solution-building clinician will stay attuned to the body language, intonation, facial expressions, and gestures of clients to provide

context and understanding of the spoken language used during a solution-building session. One participant mentioned,

> "Although non-verbal language is attended to by SFBT clinicians, it was asserted that experts rarely overtly mention these non-verbal processes, but rather "listen to" [them] without [making] assumptions about what that language means."

Therapeutic alliance is equal to solution-building language

SFBT expert participants emphasized the importance of a therapeutic alliance within psychotherapy and often commented that it was the "most important element." The majority of participants alluded that the alliance in SFBT is synonymous to this collaborative, co-construction of language process. For example, one respondent mentioned, "I'm not sure…how (a therapeutic relationship) differs from collaboration. If you have collaboration, then surely you have an alliance. And if you don't, therapy will fail." If SFBT clinicians stay true to the solution-building conversation an "alliance" will naturally develop as the client hears his/her words being used accurately by the clinician and thus will feel heard and understood by the clinician. Some clinicians discussed getting background information about the client as part of alliance-building; however, others mentioned that background gathering was unnecessary and that a positive therapeutic alliance was only dependent on using the client(s)' exact language in a solution-building way. Almost all participants mentioned that the basic "respectful" and "curious" stance of SFBT practitioners creates an environment that fosters this collaborative therapeutic alliance. Another respondent's comments seem to reflect the view of many of the participants:

> "I like [Steve de Shazer's] comment that [the therapeutic alliance is] usually there from the beginning and it's our job not to lose it. Personally I was once aware, when someone was practicing [sic] [the] SF approach on me, that it wasn't there.… her manner/questioning was wrong for me. So I think it's perhaps easier to tell when it definitely isn't there—the rest of the time it's there and you just get on with the conversation."

In addition to comments made by participants about the therapeutic alliance, there was specific attention to what clinicians do in order to solution build with their clients.

Clinician's role in solution-building

The clinician is the expert of the collaborative, therapeutic solution-building process. Outlined below is what the solution-building professional does in order to properly engage in the solution-building process. The clinician demonstrates his/her expertise through skillfully/artfully engaging in a three-step recursive process of listening, selecting and building. *This three-step*

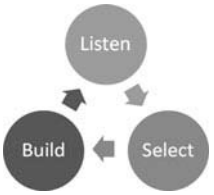

Figure 1. Clinician's role in solution building.

recursive process is the essence of how solution-building is done! An expert SFBT clinician uses their individual skills and abilities to, (1) listen intently to the client's exact words while noting the client's preferred future and exceptions to the problem, (2) select aspects of the client's preferred future (i.e., punctuates through purposeful questions and/or solution-building formulations and compliments) while incorporating the client's language (often exact words), while overlooking (i.e., not commenting on, as opposed to ignoring) the client's non-solution-building language from the client, and (3) build, by getting rich, detailed descriptions of the client's preferred future or a particular exception, as well as the client's successes and desires (See Figure 1). One participant outlined this process in this way, "Asking questions, LISTENING to the answers, and laser-focusing on answers that indicate a previous solution, or small change, or future hopes."

The clinician further builds by making these small, specific details overt. Throughout this process the clinician accepts the client's account and works from the assumption that clients are able to engage in/participate in a solution-building conversation ("trusts the client").

It is important to note that many participants mentioned that this artful expertise is developed through experience and sometimes, significant amounts of practice.

One respondent outlined this solution-building process nicely,

> "Critical in this cooperative conversation is the therapist's attending to and selecting out the client's language (words and phrases) for what the client wants, hints of past successes, inner and outer resources. Once selected, the therapist then incorporates these words into the therapist's next questions and/or formulation. I think of this process of listen, select, and building in a SFBT direction incorporating the client's language. With each therapist SFBT question and/or formulation, the client generally cooperates by providing an answer or making a comment that the therapist again connects to by listening, selecting, and building the therapists (sic) next SFBT question or formulation."

Clinicians individual skills

Respondents often mentioned skills that enable a clinician to be an effective solution builder with clients. Some skills mentioned include: good listener,

curious, persistent, respectful, accepting, hopeful, having a sense of humor, genuine, logical, nice, and reasonable. One participant mentioned that,

> Clients often struggle to put words to what they might want—so what they want generally must be built through cooperative interaction. So being able to keep asking meaningful SFBT questions and making SFBT formulations is key to being an effective SFBT therapist.

In addition, many individuals mentioned that there was some "unlearning" that needed to take place in order to be an effective solution builder. Many participants mentioned that their formal education in psychotherapy had encouraged them to focus on problems, provide psychoeducation, overtly direct the session or provide the client(s) with advice. Several participants mentioned that in order to become an effective solution builder, practice was necessary to "unlearn" other methods and/or therapeutic interventions. Although it can appear easy at first glance, closely listening to the client(s) and guiding clients to begin looking at a preferred future takes discipline and deliberate effort and may be a different skill-set than is required when doing other forms of therapy.

Although clinicians are the experts of this solution-building process in therapy the client(s) are obviously integral to this recursive process as well.

Client(s)' role in solution-building

The client(s) role in this process can simply be stated as participating in the solution-building conversation. Several participants noted that just by responding to questions by the therapist, the client was fulfilling their role. In addition, solution-building clinicians get clues that their clients are solution-building within a single session or over multiple sessions; these clues might include, "provid(ing) more and more details about what they want," "looking thoughtful," or even saying, "I have never thought about it like that." The solution-building client describe his/her preferred future with more and more detail and thoughtfully consider pieces of the preferred future that may already be happening, while considering what small step(s) are feasible to take next. The solution-building client will also concentrate and potentially become increasingly thoughtful about the conversation/questions and formulations from the therapist over the course of a session and will respond in the most accurate way they can. In addition, a SFBT therapist can note that a client is benefiting from this solution-building process as the client(s) expresses more optimism about the future and may overtly mention that things are better.

One participant summarized the collaborative relationship between solution-building clinicians and clients by saying,

> "(The clients) are solution-building when they provide more and more details about what they want. . .. However, this is a co-constructive process, so whether they are doing this or not is tied to what the therapist is asking and formulating."

Solution-building conversations require clients and clinicians collaborating together and these solution-building conversations vary drastically from problem-solving conversations.

Problem-solving versus solution-building

It was abundantly clear that SFBT experts believe that solution-building and problem-solving are completely distinct processes; only one respondent commented that these processes were the synonymous. Despite this consensus, a point of clarification is needed; although solution-building and problem-solving are very different processes and involve different strategies, the same exact words (language) may or may not be utilized to solution build and/or to problem solve. The fundamental difference between these two processes is the client(s)' language that is selected and how it is amplified by the clinician. One participant mentioned, "Problem-solving needs a problem to be solved. Thus a problem needs to be constructed. Solution-building needs a goal to work toward. Thus a goal needs to be created."

Problem-solving language focuses on the problem (often with a past focus; i.e., what has happened previously that has contributed to this problem) and what effort is needed to arrive at that solution, often in a linear fashion, whereas solution-building language is a detailed account of what they would like to be different (a future focus, despite the potential presence of a problem). Another participant responded,

> "Problem-solving is focused on the details of the problem; etiology, presence in every day life. Problem-solving is a structural activity that seeks to uncover reality. Solution-building focuses on exceptions and future projections. The effect of solution-building is co-constructing reality with clients. In problem-solving, meanings are fixed and independent of context. In solution-building meanings are fluid and dependent on context. In problem-solving the goal is to arrive at THE solution to the problem. The goal of solution-building is for the client to help discover A solution that works for him or her."

Although there was significant consensus among this group of SFBT experts regarding the definition of solution-building, the clinician's role, as well as the client's role, there were some individual participants who did not agree with the overall group sentiment. A description of their disagreement is presented in the *Contrasting Picture* section below.

Contrasting picture

Not all SFBT experts conceptualized what they do in the same way. Among the areas of minor disagreement were; goal focus, role of the clinician, attention to emotion and non-verbal communication, and the meaning of a therapeutic alliance. A list of exact quotes is provided here to show these areas of disagreements that contribute to a contrasting picture of what solution-building is. It is important to note that these responses represent a significant minority of respondents; however, the authors felt that to fairly represent the findings, these points needed to be included. These points will not be discussed at length, again because they represent the great minority of participants' views.

(1) "Solution-building is an unhelpful distortion of what SFBT is."
(2) "Solution-building is brainstorming a solution and then moving toward it."
(3) "The therapist is supposed to craft small steps that the client is willing to do to move toward the desired outcome."
(4) "I would try not to (attend to non-verbal language)—to difficult to know what it might mean and it is likely to get in the way of listening to what the client is saying."
(5) "Emotion does not play a role (in solution-building)."

- "Giving space to attending to the therapeutic alliance never seemed important in SFBT writing."

Discussion

This study did have some limitations that are worth mentioning. First, we were unable to include the voices of all SFBT clinicians. Some prominent SFBT clinicians and many non-prominent clinicians were excluded based on the inclusion criteria that were purposefully narrow. Although these criteria resulted in an impressive pool of candidates, it may have excluded potential participants who could have meaningfully contributed their knowledge and experience to the discussion on solution-building, particularly some practitioners who have not contributed to the SFBT literature, but who have "real-world" experience and knowledge. Second, the lack of live conversations may have resulted in misunderstandings or misrepresentations. Although the researchers tried to eliminate this by using multiple rounds of questions and checking in with participants, they may not have been able to

communicate in writing what they could have communicated by speaking, nor was there an opportunity to ask clarifying questions.

Despite these limitations, the results of this study yielded a definition of solution-building (a collaborative language process between the client(s) and the therapist that develops a detailed description of the client(s)' preferred future/goals and identifies exceptions and past successes) and delineated what the solution-building process is, as well as the roles the clients and the clinicians play in this process. It should be emphasized that solution-building occurs at the language level, which is consistent with the way the approach was outlined by the founders of the model, Steve de Shazer and Insoo Kim Berg (De Jong & Berg 2013; de Shazer et al., 1986). However, additional clarification was added during this study about what this means.

The *listen, select, and build* pattern of these conversations is a more detailed description of how these solution-building conversations happen than has been outlined previously. Recently, De Jong and Berg (2013) outlined a similar pattern in their updated edition of *Interviewing for Solutions* and this description has been incorporated into the updated version of the Solution-Focused Brief Therapy Association's treatment manual for individuals (2013). It should be noted that these updated versions were published after the data for this study were gathered and analyzed. However, the convergence of findings from this study with the most current literature is encouraging. The expert participants in this study believed the *listen, select, and build* process to be a key component of solution-building. We advocate that if clinicians can learn to do this language process effectively, they will be working consistently within the SFBT framework. Several participants mentioned that some "unlearning" of other techniques or approaches may be necessary in order to effectively solution-build with clients. However, it was noted by the SFBT experts that SFBT therapists who solution-build trust that the collaborative conversation will lead to change and that no additional work is necessary to created needed change. Therefore, SFBT clinicians should attend whole-heartedly to the language their clients' use, select pieces that focus on the preferred future, while encouraging their clients to provide more and more detail about life when the preferred future has been realized.

A clinical and training implication of the findings from this study is that solution-building clinicians do not need to understand the nuances or necessarily use SFBT "techniques" or "interventions." A common critique of SFBT is that the therapeutic questions like the miracle question, scaling questions, etc., are simplistic and mechanistic, and are not customized to each unique client (e.g., Dermer, Hemesath, & Russell, 1998; Walsh, 2010). It should be highlighted that throughout this study these specific "techniques" were not mentioned by the participants. Rather the SFBT experts, as a group, focused on using the *listen, select, and build* process, although they may not have called it this. This process necessitates that clinicians customize each

question or statement to the individual client(s) sitting in the room rather than asking a question from a pre-selected list of possibilities.

As clinicians listen to and select their clients' meaningful words the need to be creative or innovative with the various pre-scripted questions is eliminated. The need to rely on scripted questions is replaced with the ability to meaningfully connect with each client by asking them specific questions that incorporate the client's own language. For this reason instructors and mentors of SFBT should help developing clinicians focus on learning how to be a solution-building clinician who attends to the unique language with each client rather than teaching a set list of techniques, that could in fact lead clinicians to ignore what clients are actually bringing to therapy. It should be noted that we are not advocating that these various questions (miracle, scaling, etc.) be eliminated, nor are we saying that they are not useful, rather we are advocating that they be utilized within the framework of *listen, select, and build* in customized ways with each client and that they may not need to be used within all sessions of solution-building work.

In addition, we suggest that as clinicians attend to the specific language of their clients they will find themselves "hanging on each word" spoken by their clients. This dependence on listening and utilizing the clients' language will provide clients with a real sense that they are understood and cared for. This post-modern, constructivist approach to developing a therapeutic alliance through language is consistent with other descriptions of positive therapeutic alliances (Sprenkle & Blow, 2007).

It should be acknowledged that there was some disagreement by a minor subset of the participants. These researchers feel that this minority voice represents a sample of SFBT clinicians who may be practicing differently than the majority of SFBT experts. Ongoing conversations should be encouraged to discover the impact of these differences on therapeutic outcomes. In addition, these researchers believe that this sample of responses serves to perpetuate negative stereotypes about SFBT and solution-building that are not consistent with the perspective or many SFBT clinicians.

This study contributes a definition of solution-building as well as a description of the solution-building process. However additional research is needed to investigate the effect that solution-building, with this level of specificity, has on clients and on the therapeutic relationship. Additional process research could evaluate if individual therapists are working consistently with this solution-building perspective and what impact this has on clients and their language during sessions. This kind of research would evaluate fidelity and could have teaching/training implications. Ongoing outcome research paired with process research is also needed to determine the impact of solution-building with various presenting problems and populations.

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