COMMENTARY
Miller and de Shazer’s Article on “Emotions in Solution-Focused Therapy”

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“Telephones are great. Every home should have one, but they shouldn’t be expected to heat the house.”
—Carl A. Whitaker

In our previous article on this topic (Kiser, Piercy, & Lipchik, 1993), we contended, among other things, that a) emotions are intertwined with thoughts and behaviors (p. 234–235), b) context serves to define emotions (p. 234), and c) solution-focused therapy would benefit from more overt efforts to include emotions into its theory and practice (pp. 233, 241). We are pleased that Miller and de Shazer agree with our modest contentions. We are also pleased with their efforts to expand the theoretical understanding of the role of emotions in solution-focused therapy.

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Clearly, context, experience, and culture all serve to shape the meaning we give our emotions. Miller and de Shazer draw heavily from the writings of Wittgenstein in their proposition that solution-focused “language games” help change the context of emotions so that clients perceive them more as resources than as problems. Like most family therapists, Miller and de Shazer try to speak in ways that create a context for both perceptual and behavior change.

However, Miller and de Shazer provide a rather detached, emotionless discussion of emotions. It is this emotion-dry, intellectual emphasis within solution-focused therapy that we tried to balance in our previous articles (Kiser et al., 1993; Lipchik, 1999). We believe that there is nothing in the basic resource-focused practices and premises of solution-focused therapy that should privilege cognitions over emotions. Unfortunately, Miller and de Shazer’s article perpetuates the notion of an erudite solution-focused therapist who plays an intellectual “language game” to reconfigure “emotion displays” (p. 17). We believe that emotions are more than “customary practices” or “social customs” (p. 16). Likewise, we see grief as more than “sympathy displays” (p. 16). We also regard “changing the ‘emotion rules’”
(p. 16) as a less than satisfying therapeutic goal.

In this language-game approach to emotions, the therapist is a master wordsmith, an expert manipulator—an image that is at odds with the collaborative co-constructivist image associated with most postmodern therapies. We believe that this language-game mind set has the potential to make clients feel not heard or understood.

Miller and de Shazer’s emotion-as-language formulations also ignore the wealth of theory and research on affect, attachment (see Cicchetti, Toth, & Lynch, 1995; Johnson & Greenberg, 1984; Liddle, 1988; Lyons-Ruth, 1996; Mackey, 1996; Robinson, Emde, & Korfmarcher, 1997), and neuroscience (see Damasio, 1994; LeDoux, 1996) in psychotherapy. It is from these literatures—and from the ebb and flow of the emotional drama of clinical experience—that we believe a fuller, more human conceptualization of affect in solution-focused therapy will emerge. We hope there is room for solution-focused therapy to benefit from such developments but, frankly, we don’t see it in Miller and de Shazer’s article.

Solution-focused clinicians need to know how to acknowledge, join with, and respond to client emotions as well as thoughts and actions. Like Miller and de Shazer, we believe it can be helpful to reframe emotions as strengths. But not all negative emotions should be talked away in therapy. Sometimes it is best simply to be with clients in their despair, grief, or depression. Also, when clients share vulnerable feelings with family members, the family often feels closer and more intimate (Greenberg & Johnson, 1988). Thus, we need not always find exceptions or too quickly move away from such emotions. Feeling talk can sometimes be the best solution talk (Lipchik, 1999, p. 177).

We note an orthodox tone in Miller and de Shazer’s article, reflected in their many cautionary and concerning regards those who conceptualize and treat emotion differently than they do. Ironically, de Shazer has been critical of such a stance in the past. For example, he has stated that, “What is difficult is when . . . orthodoxy sets in, so somebody’s more right than somebody else in their interpretation” (Kiser, 1995, p. 167).

We see elaborations of solution-focused therapy more in the context of the change that occurs when theories are tested and shortcomings come to light in practice (Kuhn, 1970). Therapeutic innovation in psychology and the introduction of new points of view are neither disdained nor necessarily bad. The development of a more emotion-rich solution-focused therapy, we believe, will bring an important dimension to this therapy.

Miller and de Shazer further state that “attempts at blending these different language games risk undermining solution-focused therapists’ interest in helping clients to develop more optimistic and self-confident expectations about their lives” (p. 15). This implies that, if we talk about emotions, we are engaging in problem talk. On the contrary: a respectful, empathic therapist must understand and join with clients, negative emotions and all. Similarly, we don’t understand Miller and de Shazer’s assertion that “therapists questions about clients’ emotions would invite answers that would confuse both the therapist and client” (p. 10). This simply does not fit our own or our clients’ experience.

Sometimes a client isn’t ready to respond to questions about exceptions, past successes, and future possibilities. We’ve noticed that clients don’t come back, or don’t progress, when the therapist is more intent on being “solution-focused” than on hearing what clients are trying to tell them. There is more than one way to teach people to dance. We can push them around

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the dance floor till they “get it.” But those who are uncertain, or not as rhythmic, may need a different approach.

We also believe that it is unrealistic to think that people should feel happy all the time. Although we all need a healthy dose of positive feelings in our lives, we can become too attached to any emotion, positive or negative. Life dishes out plenty of challenges; so there is wisdom in learning to accept, cope with, and even make friends with a wide range of emotions.

Just as emotions are affected by context and culture, so are therapeutic theories. My (DK) doctoral dissertation involved interviewing 13 of the founders of solution-focused therapy. I found that solution-focused therapy mirrored the personalities of its founders in many ways. According to one of my respondents, for example, most of the founders of solution-focused therapy did not see affect as a point of intervention, but as a by-product of cognitive processes (Kiser, 1995). Another founder stated that “...a model which makes us engage in long intimate struggles doesn’t fit for any of us” (p. 142). Similarly, Steve de Shazer stated at the time that he saw little use for affect (Kiser, 1996, p. 141), or, for that matter, for certain relationship skills that help therapists connect with clients, such as making eye contact. “I don’t think it’s important,” he stated. He indicated that he did not know whether clients liked eye contact or not. “It’s not important, whether they like it or not,” he said (p. 141).

In sum, we are pleased that Miller and de Shazer are attempting to integrate emotion into solution-focused therapy. However, their presentation of solution-focused therapy as a Wittgenstein language game seems unnecessarily cognitive and detached from human experience. In privileging the head over the heart, the authors succeed in avoiding intimate struggles in therapy, but at what price?

Solution-focused therapists who fail to connect on an emotional level with their clients, we believe, are less effective. Moreover, Miller and de Shazer’s methods place the therapist in a rather noncollaborative, expert role. From our point of view, this language-game approach to emotions will be less than satisfying for most therapists and clients. As Carl Whitaker was fond of saying, “Telephones are great. Every home should have one, but they shouldn’t be expected to heat the house” (Neill & Kniskern, 1982, p. 165).

REFERENCES


Liddle, H. (1995). Conceptual and clinical dimensions of a multidimensional, multi-


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