YOU ARE HOLDING 1.5 CEs IN YOUR HAND!

NASW is pleased to offer this FOCUS Homestudy Course.
How it works: Read this CE program, complete the post-test on page 17 and mail it to the Chapter office with your check. Score 80% or better and NASW will mail you a certificate for 1.5 CEs. It's that easy!

With this format and our HomEd audio programs, the Chapter continues its goal of ensuring that social workers, including those with mobility or other impairments, are able to meet their continuing education requirements. This course of 15,000 words meets the current Massachusetts Board of Registration's requirements for 1.5 CEs and is appropriate for social workers at all licensure levels. If you have comments, concerns or other questions please e-mail chapter@naswma.org or call 617-227-9635 x17.

Introduction to Solution Focused Brief Treatment

Learning Objectives

Participants in this CE Program will:

1. Understand and be able to apply the Solution Focused assumptions to their cases.
2. Be able to explain the client-therapist relationship to each goal in any particular case.
3. Articulate the concept of exceptions and be able to articulate examples of active and passive questions.

This 1.5 CE program on Solution Focused Brief Treatment is intended to introduce readers to the basic concepts of Solution Focused practice. (It is not NASW's intention that you will be able to practice Solution Focused Therapy after reading this article.)

Introduction to Solution Focused Brief Treatment

There is nothing new about brief treatment. Most clinical programs have some course work on the various forms of brief treatment, and many trainees are exposed to the philosophies and assumptions of brief models of therapy. What is new is the demand on social workers to do brief therapy in a wide variety of clinical settings and with a variety of presenting problems.

Despite the fact that there is a huge demand for briefer work primarily due to the proliferation of managed behavioral health care, there has been very little discussion about becoming briefer in our work. Treatment models are presented as a distinct protocol and the demand is clear; however, the guidance for how to integrate the concepts is too often missing. I believe that clinicians who learn to do more focused and briefer work will integrate the concepts into their existing clinical practice rather than becoming exclusively a Solution Focused therapist. When clinicians attempt to integrate the Solution Focused model into their clinical settings they are frustrated not because the techniques are too difficult, but because the systems in which clinicians work and the assumptions under which they work are not changing and adapting at the same pace as the clinicians. It appears counterproductive to have highly trained, focused clinicians working for an organization that demands a fourteen-page intake evaluation on every client. I am not, however, suggesting that there is no usefulness of such evaluations. I contend that they serve a different paradigm. Time and again I have consulted to systems needing to be overhauled to meet the demands of briefer work and to provide adequate support to clinicians. In my experience, what drives an organization is its assumptions and paradigms. These dictate the work of the clinicians and the rest of the staff. As you read through this article you will find that you easily agree with some statements and struggle with others. I suggest that when you encounter a section that is difficult for you to agree with, you begin by asking yourself what it is that you believe that makes it difficult to agree with whatever you are reading at that time.

The Background of Solution Focused Brief Therapy

Solution Focused Brief Therapy has been in existence for over twenty years. Steve deShazer is credited with beginning the model at the Brief Family Therapy Center in Milwaukee, Wisconsin. Many clinicians who have trained with deShazer and his partner, Insoo Kim Berg, have changed and adapted the model to fit their own assumptions and needs of practice. These include but are not limited to Dr. Scott Miller, Larry Hopwood, Michele Weiner-Davis, William O'Hanlon, Patricia Hudson, Yvonna Dolan, John Walter, Jane Peller, and others. There are several good resources that detail the development of Solution Focused Brief Therapy (deShazer, 1985, 1988, 1994; Berg & Miller, 1992; Hudson & Weiner-Davis, 1989). Readers can consult these resources for further information.

Solution Focused Therapy is not just long-term therapy done faster or in a shorter period of time; it is a different approach to working with clients. Most of the traditional forms of psychotherapy begin with the therapist developing a diagnosis, then treatment goals. This model starts with the client and focuses on solutions. My clients report to me that my work provides them with hope and control over the pace and focus of the treatment. I have found Solution Focused Therapy to be very respectful of cultural difference and a variety of world views. The model has also helped us to treat each client as an individual and approach each new case with an open mind filled with wonderment. Another important aspect of the model is the ability for clients to measure, through the scaling questions, their own progress. It is wonderful in treatment when we recognize that our clients are improving, feeling and doing better; it is much more powerful when our clients recognize this in themselves. Solution Focused Therapy focuses on the present and future, utilizing the past as it is necessary to help get the client unstuck. The model is non-pathology based. It is important to realize that the intent is to be solution focused, not brief. The fact that the work is briefer is an added benefit of being Solution Focused. It is important to emphasize that Solution Focused Therapy is not better or worse than any other form of treatment, in regard to treatment outcome and client satisfaction, although there has been very little research done in this area (Miller, 1993a). I do believe that what I do during a session is different; however, the results are not different (for further discussion see Miller, 1993a). I have found that some clinicians gravitate toward a Solution Focused approach

and are able to successfully embrace the assumptions. The model does not work for everyone. Although the field of mental health is undergoing a dramatic change at this time this does not mean that this model is the answer. I encourage clinicians to study this model, evaluate it, and learn about a variety of brief therapies. As many Solution Focused clinicians believe, if this were the model, we would all be doing it.

Assumptions of Solution Focused Brief Therapy

The assumptions that we hold about our work and our clients drive the type of clinical work that we do. By assumptions we mean our thoughts, feelings, values, and attitudes that affect our work with clients. As Moshe Talmon points out, "Therapists' attitudes are critical to the way they operate, think, and feel in the process of psychotherapy" (Talmon, 1990). Our assumptions are a guiding force in the work we do and influence both our clients and us. As deShazer, et al (1986) stated:

Therapists need to make some assumptions about the construction of complaints and the nature of solutions in order to do their job. (Although our assumptions are somewhat idiosyncratic...) Let's say that the therapist assumes that "symptoms" have a systemic function - they hold the family together. In this case he or she will draw a map that suggests how that function can be served in that system without the symptom. (Brief Therapy: Family Process, p. 210)

How do we decide which assumptions are right for us given all of the different theoretical perspectives which appear to be equally valid and helpful to the client? An exploration of the general influence, creation, and maintenance of our assumptions is a good place to begin.

As therapists, we use the therapeutic interview as our intervention. The relationship and interaction between client and therapist is paramount. Therefore what we ask during the interaction becomes crucial since our questions are how we operationalize our intervention. All therapists accomplish three tasks during a session regardless of one's therapeutic orientation. We elicit, amplify, and reinforce information (thoughts, beliefs, values, feelings, behaviors). What we choose to elicit, amplify, and reinforce varies greatly, and consequently, the information we obtain will vary. If we walk into a room and start a conversation about fly-fishing (even though we know nothing about it), in some manner or another we are going to be talking about fly-fishing. Similarly, if we ask clients about problems [diagnosis, history, their mother], we are going to engage in a conversation about problems. It has typically been many clinicians' experience that clients will follow our lead in an effort to cooperate with us (Berg & Miller, 1992). Therefore it is crucial for us to be cognizant that whatever we ask about becomes the focus and direction of the therapeutic encounter.

Sources of Assumptions

If assumptions are paramount to our work, where do they come from? People go into the therapy field with a portion of their assumptions already in place, while others are acquired. A therapist's prior experience doing counseling, giving advice, solving problems, and being a client can influence his/her assumptions. During a professional's training, assumptions are rarely discussed directly - ours or our clients'. On the basis of our training, some assumptions that many of us have believed are: [Clients need help; we can provide help; some people need more help than others; take nothing at face value, there is an underlying reason for the problems you are seeing and your job is to find it; there are some people who have a high level of insight and some who don't; some people are more ready and willing to be in therapy than others; think systemically;] and more. This list is not completely conscious, and it is definitely not stagnant.

In the past, depending on the client, insurance company, presenting problem, supervisor, agency, mood, weather, and what training I had most recently been to, my assumptions would fluctuate above and below the conscious level. Most influential was the diagnosis; I was trained to believe this would somehow indicate a treatment direction. If I could accurately diagnosis the problem, then I could find the answer and supposedly know what I should be doing while sitting across from my clients. In practice however, this is not always the case. Assumptions about our work and our clients tie in closely with our values and the nature of the work we do (Miller, 1993b). Our beliefs are based on our subjective thinking. Given that there is little if any empirical evidence to suggest that one type of treatment is any better than another (Miller, 1993a), clinicians should at least be aware of our own assumptions that lead us to do a certain style of counseling.

During the many trainings I conduct I spend considerable time asking trainees to explore their assumptions. The process usually starts off slowly; people are either shy or unsure about articulating their assumptions. For many this is the first time that they have been asked to explore their assumptions. It is important to emphasize that assumptions are not wrong or right, they just are. For example, one assumption that we hold is that "it is unnecessary to know a lot about the problem in order to resolve it" (deShazer, 1988). Another therapist may hold the assumption that he/she needs to know a lot about the problem in order to resolve it. Both of these assumptions are valid in my opinion. Depending on which assumption you hold, it is my contention that you will ask very different questions, you will get different answers, and treatment will move along in different directions. For example, if we assume people have the strengths and resources to solve their own problems (Rabkin, 1983; O'Hanlon & Wilk, 1987; O'Hanlon & Weiner-Davis, 1989), we might ask, "How did you solve this the last time?"

In an effort to clarify our assumptions it has been helpful for clinicians to ask themselves what assumption a question is based on, and then work backwards to the basis of that question. For example, if we ask a client "How can I help you solve your problem?" We are assuming that (1) we can help the client, (2) there is a problem, and (3) the client wants our help with this problem. In addition, when we hear an assumption that we do not agree with we can ask ourselves what assumption we do believe. Very often during team meetings with five therapists in the room, we will have seven opinions. I believe this is caused primarily by our different assumptions. I feel that it is important to be aware of our assumptions for several reasons. Doing therapy has never been, and will most likely never be, an exact science. In an effort to be as consistent as possible, I have found that having a clear understanding of the forces that drive our work is a key step. The more consistent we are in our work, the better we are able to evaluate its effective-

ness. In addition, knowing our current assumptions allows us to better evaluate new models of treatment, new techniques, and the assumptions on which they are based.

Maintenance of Assumptions

The first step in changing our assumptions is to explore them. The easiest way for us to do this is to think about our assumptions and have several different sets of assumptions clearly defined for us. As you learn about the assumptions of Solution Focused Brief Therapy (deShazer, 1985, 1988; deShazer, Berg, Lipchik, Nunnally, Molnar, Gingerich, & Weiner-Davis, 1986), you will be able to compare and contrast these assumptions with your own as you become aware of them. Even if you do not agree, you are still able to ask yourselves what assumption you do believe, where had it come from, and does it "fit" well with who you are as clinical social workers at this time. This exploration (questioning) is not always a very uncomfortable endeavor. It can take many conversations with other clinicians who are thinking about the current trends in mental health to sort out your assumptions and to identify their origins.

Knowing what assumptions we believe can help us in our work. Talmon (1990) refers to assumptions as attitudes. He states, "Attitudes play a central role (emphasis added) in all forms of psychotherapy. Evidently, therapists' attitudes are expressed in their first questions in the initial session." In a Solution Focused session one of the first questions we ask our clients is, "What brings you here today?" This question is based on the assumption, that clients set the goals of treatment (O'Hanlon & Weiner-Davis, 1989). By believing that clients should set the goals, we can then formulate logical and consistent questions based on this assumption. I often get asked by clinicians who observe a Solution Focused session, "How did you know to ask that question?" The answer is that I base my questions on my assumptions, and since I try to be clear what my assumptions are, it becomes easier to know what question to ask next.

As mental health services continue to undergo radical changes in the era of managed mental health and budget cuts, social workers will be challenged to continually adapt to new settings, rules, requirements, and therapy techniques. In an effort to acclimate to these changes, new techniques that arise, or old ones making a resurgence, it is vital to be cognizant of our assumptions. As we are called upon to change, knowing where we are coming from becomes even more important to help us get to where we want to go.

Assumptions of Solution Focused Brief Therapy

What follows are the Solution Focused assumptions as I interpret them. These are similar to other explanations of the Solution Focused assumptions (deShazer, 1985, 1988; Berg & Miller 1992; O'Hanlon & Weiner-Davis, 1989; Walter & Peller, 1992) and have been expanded and interpreted to fit my view of the model It is not necessary to believe all of the assumptions in order to practice Solution Focused Therapy. All of the questions I ask in a session are based on at least one of these assumptions. If you do not agree with one of these assumptions, I encourage you to ask yourself what assumption you do hold that makes it so you cannot accept this Solution Focused assumption.

If it works, do it more

This assumption applies to both the social worker and the client. With respect to the social worker, if we are working with clients who are reporting progress toward their goals, we continue to do the same intervention that we are doing. When we are working with a client and the client reports that things are better, we should spend most of the session amplifying this progress and who was involved in this progress. Here we can ask interactional questions in the amplifying process. Of course, we are assuming here that our intervention has something to do with the client's progress. Most social workers assume they are somehow partially responsible when a client gets worse, so it only seems fair to be consistent and blame ourselves when clients get better. This is sometimes an uncomfortable way for social workers to think. I believe it is just applying the same principle to both situations.

The key point is progress toward the clients' goals, not the therapist's, agency's, or society's goals; even though the clients' solution may not be the one the therapist would prefer, this assumption encourages the therapist to tell the client to do it more. This helps the client to build patterns of success. It is important to highlight these patterns, and not suggest "better" solutions, which can confuse and disempower the client.

Sometimes, clients are not aware of their own progress. This is a time when the therapist's skills of amplification and reinforcement are crucial. Many times, if you ask clients about pre-session change (Weiner-Davis, deShazer, & Gingerish, 1987), they will report progress toward their goals. As illustrated by a study conducted at The Brief Family Therapy Center in Milwaukee, Wisconsin, in 1987 (Weiner-Davis, deShazer, & Gingerish, 1987), when clients were asked about change even before therapy began, many reported positive change. Weiner-Davis asked each client coming in for therapy, "Many times people notice in between the time they make the appointment for therapy and the first session that things already seem different. What have you noticed about your situation?...Are these the kinds of changes you would like to continue to have happen?" (Weiner-Davis, deShazer, & Gingerish, p. 360). Sixty-six percent of the sample reported that they had noticed some difference and it was the type of difference they would like to happen more. If expanded beyond the scope of this research, the potential exists that for two out of three clients coming to see us, they are already doing something to improve their situation! Although this is not "fact," it is intriguing to entertain this thought when seeing clients for the first time.

If it is not broken, don't fix it

Solution Focused clinicians work hard to cooperate with clients. Part of this cooperation involves allowing clients the autonomy to decide what goals they want to work on with us in therapy. It is important to remember that as therapists we have several roles in society that at first glance may seem to contradict or be in direct conflict with this assumption. I view mandated reporting as the exception to this assumption and believe that one of the important aspects of my social work profession is to act as a social control agent (Dawes 1994). When I have to file some sort of abuse or neglect report, I know that I am not being Solution Focused, but I also know that I am being a good social worker. It is possible to be clear about why you are doing something, which allows you to

continue to work with clients in a Solution Focused manner.

This assumption creates a great deal of respect for our clients and encourages client self-determination. It also helps us to be sensitive to, and respectful of, cultural differences among our clients, and between ourselves and our clients. We are also careful not to add problems to our clients' list. This is sometimes very challenging, particularly when we recognize issues that we are trained to notice. For example, when a client presents with "communication" issues in a marriage and we suspect the client may have a drinking problem, we begin by agreeing with the client's view of the world, and at that time do not confront the client about the suspected drinking. What makes following this assumption easier is the next assumption.

Clients have the resources and strengths to resolve their complaints

One of the most difficult assumptions for many social workers to adopt, having been trained in a psychodynamically oriented model, is that clients have the resources and strengths to resolve their complaints. Solution Focused Brief Therapy truly believes that clients are their own best experts. Oftentimes people confuse this assumption and do not allow others in the clients' system to help them fix the problem. Family members, others in a therapeutic milieu, a religious leader, and group members can help form a solution; the key is that the onus is not on the therapist. Putting this into practice is easier said than done. I utilize the Solution Focused technique of looking for exceptions to help us in this endeavor. This will be discussed later in this article.

When we take our car to the garage, we do not need the mechanic to spend forty minutes explaining to us why our car will not start. What we need is for her to fix it. Although the analogy is not perfect, I do not assume that clients need me to explain their problems. I have found that there is a distinct difference between what people tell us is wrong, and what they want. In fact, many times these two are not as related as we might assume. In other words, the solution is not necessarily the anti-problem. It is important to allow clients to tell their story, as mentioned previously; however, their story may mostly be a good source for gathering information which may help you fill out forms and billing- two events we distinguish from doing therapy. For example, when clients come in and say they are depressed, I would ask the following:

CLIENT: I'm depressed and I need to know why.
THERAPIST: If you were no longer depressed, but you never knew why, would this be good enough?

Most clients tell me that it would be good enough to just not be depressed anymore. Those who say no, it would not be good enough (many of whom are therapists themselves), have a very legitimate reason. If they do not know why they were depressed in the first place, they are concerned it will happen again, even if they stop being depressed for a while. In this case, it is the clients' need to explore why they are depressed. With clients who have this need, I will begin by asking them their theories about why they are depressed. These typically range in number from one to five reasons (depending on whether they have been in therapy before and how long they have been depressed). I have yet to meet a client who has no explanations. I work to validate their explanations. The exception to this assumption is when I feel that a client's explanation is self-destructive or bizarre thinking. In these cases I would challenge these beliefs and ask questions to elicit alternative explanations. This assumption contradicts a long-term insight-oriented therapy assumption that insight leads to change. Instead, Solution Focused clinicians believe that insight leads to insight, but in order to change you must gain some new insight. This is why we initiate the "solution talk" early in treatment, so we can begin the work toward change.

CLIENT: I need to know why I am depressed.
THERAPIST: Okay, suppose you weren't depressed anymore, but you never knew why you were depressed in the first place. Would that be good enough? (If the client says yes, which most do, then you can move on to ask about the solution by asking The Miracle Question. Below I will dialogue what I say when someone says that won't be sufficient)
CLIENT: No. I need to know why, otherwise it will just happen again.
THERAPIST: You are right (I always agree with my clients). Okay, you have probably given this a lot of thought. What are your thoughts about why you are depressed? (People always have an answer; you just have to wait for them to say it.)

CLIENT: Well, I think part of the reason is my mother is depressed.Then, I haven't even told you about how my parents made me goto camp in the summer, which I hated. Also the kids used to always pick on me at school. (I will encourage all the explanations this person can remember.)
THERAPIST: Those all sound like difficult things to handle as a kid and seem like good reasons for being depressed. Can you think of any more things that might be relevant?
CLIENT: Well I haven't even told you about when my grandmother died and I wasn't allowed to go to the funeral. (Here I will explore this, and ask what the client would have liked to do so she felt like she did a good job saying good bye to her grandmother. Once I feel like the client has expressed all the possible explanations, without asking why the client thinks this has caused the depression, I make one of our most powerful statements)
THERAPIST: You have clearly given this a lot of thought and I think your explanations and ideas are right on. I agree with your ideas about why you are depressed. I am so glad that you have given so much thought to this, because now we know why you are depressed. All the things you mentioned are absolutely reasons to be depressed. (Here is an important next step to remember to say). So, now that we know why you are depressed, what do you want to be different? (Now this person is in the same place as the person who said I don't need to know why I am depressed. Both clients are ready to talk about solutions and how they want to feel.)

There is no one right way to view things; different views may be just as valid and may fit the facts just as well

When clients give an explanation for why things are the way that they are, I accept it, with the exceptions noted above. Although our explanations usually fit our world view better and are based on experience and clinical training, they do not necessarily fit our clients' world view better than their own. This assumption also demands that we respect other cultures and belief systems. Instead of assuming that we know best we must listen to our clients and understand why they think the way they do. We must also suspend our belief that we know best and listen to our client's explanation of their problems. As deShazer (1994) so adeptly points out, our job is to read the lines, not between the lines. After fully validating our clients' view of the world, regardless of their explanations, my question is the same: "Now that you know why, what is it that you would like to be different?"

A small change is all that is needed. A change in one part of the system can effect a change in another part

The systemic view that no part of a system can go unchanged without affecting other parts of the system is a popular belief in systemic thinking (Berg & Miller, 1992; Rossi, 1973). Our job as therapists is to look for small change, and to train our clients to look for the small change. Many people whom I counsel can articulate what they want - their goals. Few however, bother to break this goal down into small, doable, well-formed goals. We have found some (mostly male) clients are big idea people, but they can't tell the trees from the forest. Breaking every goal down into small parts is essential to the goal's success.

CLIENT: I want to be able to communicate better with my wife.
THERAPIST: What will be the first signs to you that you are beginning to communicate better?
CLIENT: I don't know...If we talked more.
THERAPIST: And what would be the first step toward the two of you talking more?
CLIENT: I guess we would need to spend some time together.
THERAPIST: And what would it take for that to happen?...

Clients learn through the therapy process to examine their own goals and to break them down into small, doable pieces. Once they accomplish the first small goal, they are usually more confident they can achieve other goals.

Clients define the goals

Although it may seem obvious, Solution Focused Therapy emphasizes working on those goals that clients identify as important. This can become challenging when clients think someone else needs to change, or that there is no problem to be worked on. I have found Solution Focused Therapy particularly useful when dealing with these clients, by utilizing the Solution Focused paradigm for working with clients. This will be discussed later in this article.

Rapid Change or resolution of problems is possible

Moshe Talmon advises:

> *Most therapists, including myself, have been trained to view psychotherapy as a relatively long process, ranging from a few months to lifelong affairs. Viewing the first session only as a time for assessment is just one example of a fragmented attitude toward the nature of psychotherapy and the therapist's role in it...Taking each session one at a time and treating it as a whole can help the therapist to make use of the present without fearing the future. It encourages both client and therapist to do something about the problem without large expenses and dependency. (Talmon, 1990, pp. 117-118)*

When we approach every session as if it may be the only contact we are going to have with that client, our frame of reference is altered from that of traditional therapy. In my practice I examine those cases that appear to be unplanned terminations. When clients do not return many therapists assume that this is an indication of treatment failure. I encourage clincians to call clients and inquire as to why they decided to discontinue therapy. Many times clients report that they received what they came for, and they no longer need our services. This can hardly be regarded as treatment failure!

Focus on what is possible and changeable rather than what is impossible and intractable

O'Hanlon and Weiner-Davis (1989) and Friedman and Fanger (1991) emphasize the importance of focusing the work on those goals that are possible and changeable. Regardless of the type of therapy you are practicing, it is important to have well-formed goals.

You get what you ask for

The most important assumption to remember is that you get what you ask for. When we enter a room and begin to discuss fly-fishing, we have some conversation about fly-fishing, despite the fact that no one in the room knows anything about fly-fishing. Similarly, when we inquire about clients' depression (problems), we are subtly and not so subtly sending the message that talking about problems is essential in order to help clients reach their goals (insight leads to change theory.) Depending on your therapeutic orientation, this may very well be the case. It is important to remember that our clients listen very carefully to every word we say. I believe that our clients think that every thing we ask about is crucial information for them to solve their problem. In many cases this is not the reason the therapist is asking the question. The Solution Focused belief is that clinicians should be keenly aware of what they are asking and the influence of their words. In order to operate therapeutically within these assumptions it is vital for us to think carefully about the questions we ask our clients, because our questions are our interventions. The litmus test I ask myself before I ask a question is, "Is the question I am about to ask going to help the client meet her goal, or make progress toward her goal?" If I am uncertain, or certain that the question will not help the client toward her goal, I refrain from asking. This is sometimes very difficult! Scott Miller tells the story of a workshop participant ask-

ing him, "What happens when you know that the question will not help the client reach her goal, but you really need to ask it? What do you do?" Scott replied, "Go home, lie down, and wait for the feeling to go away" (Miller, 1993b)

Assumptions that challenge you. When thinking about the assumptions with which you cannot agree or are not sure where you stand, I encourage you to think about your assumption that makes it difficult to agree with the Solution Focused assumption. What you will find is that these assumptions will be the most challenging for you when it comes to asking Solution Focused questions. One experiment to try is to pretend you believe a specific assumption and experience what it is like to ask questions based on that assumption. This is a challenging way to work with clients and may take some practice before you feel comfortable. Another suggestion is to videotape a session and then review your questions and how they might shift if you changed some of your assumptions.

Why is it briefer? Although not the original intention, Solution Focused Therapy has been marketed as brief therapy. Clinicians have found that one explanation for this can be found with the assumption, "The therapist's job is to identify and amplify change. It is usually unnecessary to know a great deal about the complaint in order to resolve it," and also the assumption, "It is not necessary to know the cause or function of a complaint to resolve it." If you do not assume clients need to tell you their entire history or explore in detail the causes of their problem, you can potentially save a large number of sessions. The exception, of course, is when clients say they need to tell us this information in order to move on, in which case we will elicit the information and validate along the way.

Cooperating with the client

Salesperson: Let's talk about your parenting, what you have already tried, and what else you could try.

Customer: Great.

Salesperson: Once we have examined your previous parenting techniques and tried some new ones we will assess our progress. If things aren't better then we can think about what else we need to talk about.

Not cooperating with the client

Salesperson: Well, I do not think that parenting is your sole problem. I think you are depressed and that is why you are having trouble parenting.

Customer: You are wrong. I am only depressed because I am not the best parent I can be. Once I fix my parenting I won't have any reason to be depressed.

Salesperson: Well, if we address your parenting without addressing your depression first the problem will stay the same.

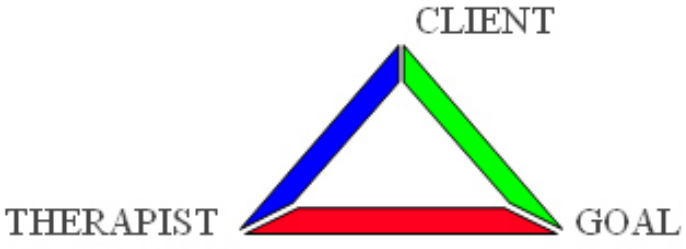
Customer: You don't understand me at all.

Articulating assumptions to clients

One of our colleagues, Bruce Deveau utilized the first three assumptions during a difficult family session. He was working with a 41 year old man who was diagnosed with obsessive compulsive disorder among other diagnoses. He had been in the mental health system for over 20 years. Bruce saw him and all the client had to say about himself was negative. Bruce decided a family session might be helpful. The client was reluctant, because the last time a therapist did a family session it was humiliating. Apparently, the therapist made him empty his pockets at the beginning of the session, and explain why he was carrying all these things. Bruce assured him this time would be different. Bruce started the session by articulating the first three assumptions of the model, and noticed the mother taking notes. He then elicited exceptions by asking each person to say one thing the client does well or one good thing about the client that the therapist probably doesn't know yet. Each person said something, and the effect on the family was remarkable. The mother commented that in the past 20 years of mental health workers this is the first time she has had a positive experience. We discussed the intervention and why the family bought into saying something positive. We believe it was because articulating the three assumptions functioned as the bridge, the rationale for saying something positive. This a great example of the power and versatility of assumptions.

Cooperating with Clients

Based on the assumptions discussed, I have found that the best way to "meet clients where they are" is to learn to cooperate with them. By cooperation I mean to believe and function as if the client's view of the world makes sense and is correct, and to communicate that we respect that view. This may seem contrary to our professional training, which teaches us to be "the experts." By cooperating with our clients in this manner we are stating that they are the experts on their lives, and we must do everything we can to learn from them (Berg & Miller, 1992). When thinking about diversity and working with clients from a different culture, this paradigm steers us toward being non-judgmental. A helpful technique in this pursuit is to classify the relationship between the Client, Therapist, and Goal into three distinct triads: customer-seller, browser-listener, and visitor-host type relationship (Berg & Miller, 1992; deShazer, 1988). These triads refer to the relationship among the three components and are not intended as labels for clients. Assessing which relationship a client is in, at any given time, for any given goal, can help us determine what role the therapist should take in the session. It is important to remember that we do not try to shift clients from one relationship to the other; we are not in the convincing business. Rather we work with our clients, from their view of the world, within the parameters of the clients' relationship to that particular goal.



The Customer-Seller Type Relationship

In this relationship, clients are the customers, and therapists are the sellers. As customers, clients give details about the problem, state that they are part of the problem, and part of the solution. Clients take some if not all responsibility for doing something about the problem. Clients in this relationship often say things like, "I have a drinking problem and I need to do something about it," or "I need to learn ways to be less stressed." The therapist's job is to help these clients reach their goals; in other words, to be a good salesperson. This can appear deceptively easy to do. For example, a parent/customer might come to see a therapist for parenting issues and the conversation might go like this:

CUSTOMER: I am really concerned about my parenting. I am not being a good parent, which is really getting me depressed. Some people in my family think I am depressed, but I think I only feel that way because I am doing such a terrible job with my daughter.
SALESPERSON: How long has this been a problem?
CUSTOMER: Since she was born. Some people suggested I take a parenting course, which I did, but it doesn't seem to have made a difference. I just don't have the energy to deal with my daughter. (At this point it is clear that the parent feels her poor parenting is causing her depression. As a trained clinician, I am thinking that she is depressed, which is why the parenting course did not solve her problem. Other people have obviously tried to convince her that her depression is her problem, but she is not a customer for that point of view).
SALESPERSON: What would you like to happen?
CUSTOMER: I want to start to feel like I am doing a good job of parenting so that I can stop being depressed.

At this point the salesperson/clinician has to decide if she is going to cooperate with the customer or add her opinion to the conversation.

In this relationship, clients are the customers, and therapists are the sellers. As customers, clients give details about the problem, state that they are part of the problem, and part of the solution. Clients take some if not all responsibility for doing something about the problem. Clients in this relationship often say things like, "I have a drinking problem and I need to do something about it," or "I need to learn ways to be less stressed." The therapist's job is to help Now, one of two things will happen. Either the customer was right and the depression will stop once she develops some new parenting skills or the parent was wrong. In the event that the parent was wrong, the parent's depression will not improve with the improved parenting and the salesperson/clinician will then get to ask the client what she thinks is getting in the way of progress. At this point most clients will say, "I guess it must be my depression." Now it is the client who is a customer for working on her depression and I didn't have to do any convincing. Typically a Solution Focused clinician will probably have lots of conversations with our client before we bring up depression and these conversations may ultimately lead to a medication evaluation. It is important to listen to our clients and believe they know what is best for them. When we do not cooperate with our clients we impose our own definition of the problem, potential solutions, and potentially other problems onto our clients.

When this conversation is applied to the area of substance abuse, it is easy to see how complicated matters can become. When we do not cooperate with our clients, we end up confronting them and trying to convince them that alcohol is the problem. The paradigm shift discussed earlier allows us to concentrate on what clients want, not what we believe clients need to do to solve their problems. We must suspend our assumptions about "how" clients will solve their problems and first discover "what" clients want. What I have found over and over again is that when clincians cooperate with their clients by asking them what they want, they are much more likely to find the solution that works for them faster than if the clincian were to impose his/her own methods of fixing problems on them. Even in the case of clients who are abusing alcohol and other drugs, we address these issues if they are central to achieving their goal (Berg & Miller, 1992).

A final aspect of this relationship is that the clinician will use active language with the client who is a customer for some of the goals. We can use active language, because the client is saying she is part of the problem and part of the solution. In the above example, we said, "what have you tried?" This implies that we know she tried something.

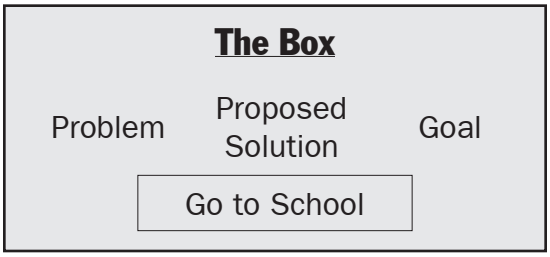
The Browser-Listener Type Relationship

In this relationship clients can tell the therapist a lot about the problem; how it started, who is involved, what keeps it going, and who has tried what to fix it. However, someone or something else must change first, before these clients can reach their goal(s). As Berg and Miller (1992) describe it, "The therapist agrees to explore the complaint or goal further with the client and to do so in a way that is intended to facilitate a new perspective that might lead to a solution." The clinician's role in this relationship is to work with our clients, challenge their beliefs when appropriate, and work toward the clients' goals. A prime example of this relationship is described by the dialogue below:

THERAPIST: So your son has been having school problems?
CLIENT: Yes, I just wish he would get up, go to school on his own, and stop messing up in class. He has always had trouble in school, since I can remember. He has always gotten extra help in school but it does not seem to be working. My husband and I have tried everything; it is up to him at this point.

Over the years it has been my experience that these are the clients with whom it is most difficult to work. Many times clinicians become frustrated with clients who blame others for their troubles, labeling these clients as resistant, in denial, or severely disturbed. Using the browser-listener paradigm allows clincians to concentrate on their clients and not try to convince them to focus on the issues they or others may perceive as the "real" problem. Oftentimes clinicians find that the client in the browser-listener type relationship ends up stuck in a box.

Suppose a client comes in stating that there is a particular problem such as in the school example above. The problem as she sees it is that he is doing poorly in school. The "solution" to her problem is that he "get up, go to school on his own, and stop messing up in

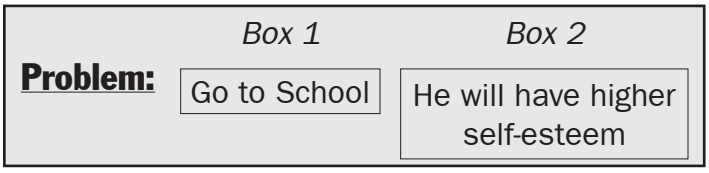


class." If I accept this as the "solution" or goal, I will be working on a goal that is poorly formed. I, however, assume that in this case, the "solution" that the client has proposed is how the problem can be solved, not what will be different when the problem is solved. The key is to inquire what will be different once the solution is successful and I ask this by incorporating the client's proposed solution into my next question.

THERAPIST: So when your son is able to go to school, what will be different?
CLIENT: He won't be in as much trouble and will get better grades. We will not get as many calls from the school.
THERAPIST: What else will be different when all that happens?
CLIENT: I guess we will not worry about his future as much and know that we can begin to trust him again.

The purpose of these questions is to help clients move around the box and start to articulate their goals, not how they are going to reach these goals. MY assumption is that the proposed "how" has not worked, or only worked to a degree. In addition, care must be taken not to land in yet another box.

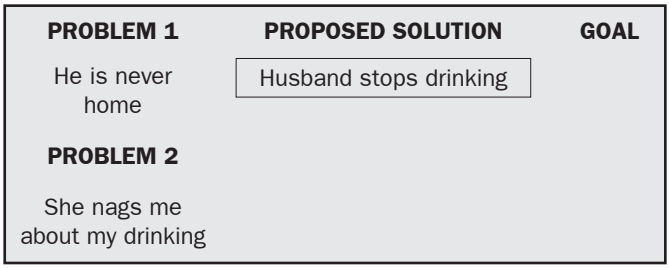
THERAPIST: So when your son is able to go to school, what will be different? (Box 1)
CLIENT: He won't be in as much trouble and will get better grades. We will not get as many calls from the school.
THERAPIST: What else will be different when all that happens?
CLIENT: I'll know that his self-esteem is higher. (Box 2)



Having "higher self-esteem" is not a well-formed goal. I utilize the same incorporation technique to get a well-formed goal from the client.

THERAPIST: So when your son has higher self-esteem, how will you know?
CLIENT: Well, he will like himself more, he will do more things like socialize, and he will talk more to me, tell me what is going on in his life.
THERAPIST: What difference will these changes make in the problems that brought you in today?
CLIENT: I will trust him more.

Another advantage of this line of questioning is that I get to further understand my clients' definitions of the language they use. In addition, clients often glean new information from their answers to these questions. In the above case the son sitting in the room hears for the first time that his mother would trust him more if he tells her more.



In some cases, secondary problems are created by the attempted "solution." In the example illustrated in the box below, the wife's attempt at solving her husband's problem has created a second problem, which is viewed as primary by the husband (Watzlawick, P. Weakland, J., and Fisch, R., 1974). The wife's proposed solution of trying to convince the husband to stop drinking creates a new problem for the husband and one that he can focus on instead of dealing with his drinking.

There is one other advantage to this type of questioning when clients begin by stating that others will change. Now and then clients will discover that they can begin to work on achieving their goals despite the fact that someone else is the problem.

THERAPIST: What brings you here today?
CLIENT: My son is driving me nuts. He really needs your help. I am very worried about him.
THERAPIST: How is he driving you nuts?
CLIENT: I just want him to get a haircut, stop listening to that damn music, and hangout with kids who can spell their own name!
THERAPIST: So when your son gets a haircut and does these other things, what will be different?
CLIENT: His grades will go up. I'll know where he is more of the time.
THERAPIST: And when you know that, what will be different for you?
CLIENT: I guess I would not worry as much.
THERAPIST: That's right. And when you are not worrying as much, what else will be different for you?
CLIENT: I won't have this tightness in my chest all the time. The doctor won't have to give me Xanax; I'll just feel better.

At the end of this exchange the client is beginning to identify goals for herself. By continuing this type of questioning the client soon realizes that she can effect her "anxiety" whether or not her son is in counseling.

In addition, I tend to use passive language with clients when discussing the goals for which they are browsers. Some passive language starts with "what needs to happen…" or "when things are better how is that happening?" I try to remember that someone who is a browser for a goal will not take responsibility for flinching first. That person's perspective is that someone else must flinch first and then he/she will flinch in response. It is most important

not to use active language with someone who is a browser for a goal. For example, I would not ask the mother in the above example, "so what are you going to do to get your son to stop listening to that music?" If I did this she would know I haven't been listening, or that I are stupid, or that I am the next person in line to think she is responsible for changing her son's behavior. If she believed any of these things about me I would lose rapport with her and that would be a mistake. Most clinicians do not have a repertoire of passive questions and shifting to being more Solution Focused requires you to develop this new vocabulary. With practice and paying attention to cooperating with clients clinicians can begin to meet our clients where they are at through our language.

Visitor-Host Type Relationship

In this relationship clients do not feel they have a problem and therefore have no goals for treatment. These clients see no reason for change. The therapist's role is to make clients in the visitor-host type relationship (to a particular goal) feel comfortable and not try to convince them that a problem really does exist. More often than not these clients have been confronted by several people about the "problem" prior to reaching our office. It serves no purpose to be the next person in the same line. Since there is no goal in these clients' minds, it would not make sense to pursue any goal. It is rare for clients to remain true visitors for a specific goal when we cooperate with their view of the world and accept their view as legitimate.

THERAPIST: What brings you here today?
CLIENT: I don't want to be here.
THERAPIST: Okay.
CLIENT: The Department of Social Services said if I ever wanted to get my kids back I had to get counseling.
THERAPIST: What would you like to get by coming here?
CLIENT: Honestly?
THERAPIST: Sure.
CLIENT: I want you, DSS, and everybody who looks like you to get out of my face, and leave me and my family alone.

At this point it could easily be assumed that this client is in the visitor relationship, not really willing to work on anything. However, we view this client in the customer-seller type relationship rather than in the visitor-host type relationship. The goal of "getting everyone who looks like you out of my face" is a goal!

THERAPIST: That sounds good to me. What do you think would need to happen for me and DSS to get out of your face and leave you alone? (notice the use of passive language)
CLIENT: (Smile, pause) They (DSS) would have to know I'm not going to beat my kids anymore.
THERAPIST: What do you think they would need to notice you doing differently to convince them of that?

By cooperating with the client's view of the world we quickly got her to talk about what she needs to do differently, and empowered her to feel in control of the treatment process.

The process of finding the goals that clients are willing to work on begins by assuming that our clients know what is best for themselves. More often than not clients end up working on those goals that "society" has deemed important, but they are doing it for their own reasons, not society's. This eliminates most cases of resistance and denial. Clients can only resist a goal imposed by someone else.

In the event that a client truly is in the visitor relationship for all goals, the task of the therapist is to make that person comfortable, and invite the client to return. From my experience a true visitor will either be able to negotiate a goal, or will not return.

To complicate the process, more often than not we find that people are in different relationships with various problems or goals. For example, a mother brought in her adolescent daughter because she had been told she had an eating disorder. The mother already had the daughter seeing a doctor and a nutritionist. After working with them for a few sessions without much progress, I finally realized my error. I had assumed the daughter was in the visitor relationship because she kept saying she did not have an eating disorder. The shift in treatment occurred when I began to examine this more closely. What I discovered was that the daughter was in the visitor-host relationship for the eating disorder, but was in the customer-seller relationship for getting her mom off her back. The mother was in the browser-listener relationship for convincing her daughter she had an eating disorder. The following dialogue will illustrate how we realized the daughter was a customer for one goal.

THERAPIST: So mom, tell me again what will be different when your daughter starts facing her eating disorder?
MOTHER: She will start eating variety. (Don't assume you know what this means. You must ask for clarification).
THERAPIST: What does that mean?
MOTHER: She will eat one new food a week. (At this point the team isn't aware of any progress, except the daughter leans forward in her chair and is interested in what they are talking about for the first time).
THERAPIST: Like what?
MOTHER: Well, all she eats are rice cakes all day. So if she ate one new food at dinner I would get off her back. (At this point the clinician realizes what has shifted, as does the daughter, but the mother still does not realize she has offered a solution).
THERAPIST: So, when your daughter eats one new food this week it will be a sign to you that she is dealing with her eating disorder and you will get off her back? (At this point the mother finally realizes what has happened. She realizes that she has given her daughter an opportunity to do something different, which she will have to interpret as a sign she is dealing with her eating disorder). Like what kind of new food?
MOTHER: An apple.
DAUGHTER: An apple. Give me a G-Damn apple and I will eat it right now and drip the juice on your leg…….(The daughter got very agitated and excited as she described what she would do. I had to calm her down so we could have a productive discussion about this new development).

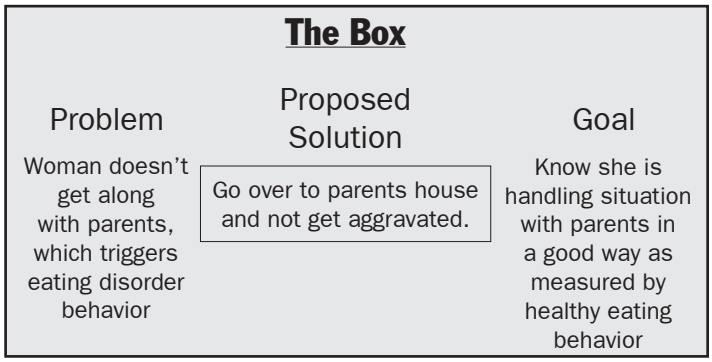
GOAL	TRIAD RELATIONSHIP
Daughter Has An Eating Disorder	Mother: Browser-Listener Daughter: Visitor-Host
Get Mother Off Daughter's Back	Mother: Browser-Listener Daughter: Customer-Seller

As the team talked about this case we realized the mother provided the potential for movement when she didn't intend to. The daughter was also a customer for getting her mother off her back and was willing to "do" something about that.

Once we realized the daughter was in the customer-seller type relationship, we gave her and her mother tasks that began to move things forward (see diagram).

Case Example: This client reported that when she goes to her parents for a visit she gets so anxious that she regresses into bingeing behavior, which then disrupts what is usually a good week. I explore what she wants to be different about this situation.

THERAPIST: So when you go to your parents you always end up bingeing?
CLIENT: Yep. It is so frustrating, and my partner doesn't understand and doesn't seem able to help me with this.
THERAPIST: Okay, are there any times when you are able to go to your parents and not end up bingeing (I am looking for exceptions here)?
CLIENT: No, it always happens.
THERAPIST: Okay, what would you like to be different about that?
CLIENT: Well, I want to be able to go over there and not get so aggravated that I end up bingeing and really feeling bad about myself.
THERAPIST: That makes sense. I am curious, do you want to go over and not get aggravated or go over and not binge? (Here I am looking to clarify the goal, which may also challenge the client's belief.)
CLIENT: Wow. That is a good question.....I'm not sure. I think it is unrealistic to think that I won't ever get aggravated over there, because my family makes me nuts and I can't change who they are, as much as I'd like to. So, I guess what I'd like is to be in control enough that I wouldn't start bingeing in order to cope.
THERAPIST: That sounds reasonable. So what would need to happen for you to be in control enough?
CLIENT: It would have to start before we got there.
THERAPIST: How would you do that?
CLIENT: Well, I have tried to talk with my partner on the way over to my parents' house and come up with a way to be supported while we are there. I know my partner wants to, but once she gets in that environment she becomes like one of them and that upsets me even more.
THERAPIST: So has this strategy worked so far?
CLIENT: I guess I would have to say no, as much as I wish it could work.
THERAPIST: What else could you do to gain some control on the way over to your parents' house?
CLIENT: Well, I'm not sure, because my partner usually drives and they don't live very far away.
THERAPIST: So your partner usually drives? (I repeated this to draw client's attention to the pattern.)
CLIENT: Yes.
THERAPIST: What could you do differently before going to your parents' house that would make you feel in control?
CLIENT: Well, now that I am sitting here talking, it occurs to me that I wonder if it would help if I drove over. I always feel more in control when I am driving somewhere.
THERAPIST: Really. That's interesting. So you are saying that when you drive you feel more in control and so if you drive over to your parents ' house then you'll gain some control and ... what will be different for you?
CLIENT: Well, I'm guessing here (this is a common qualifier), but I think that if I can drive over and feel in charge then I will enter their house feeling more empowered, and it won't bother me as much when they start doing their thing.
THERAPIST: Okay. What else will be different for you?
CLIENT: If I can feel in control then I won't need to binge in order to gain some control and then I will really feel stronger when they all start picking on me. I think my partner will probably notice and maybe even come to my defense for a change...although I won't count on it.
THERAPIST: This sounds like an interesting solution to try. How confident are you that you can do this?
CLIENT: Oh, very. I don't think it will be a big deal for her to let me drive over.



In this example the client was able to shift her proposed solution from talking in the car ride over to driving there herself. This slight shift involved some insight on her part. I purposely did not make the suggestion that she drive over to her parents' house. Rather, I asked questions about the pattern and let her come to this solution. I find this to be a very challenging aspect of this model. Clinicians have often asked me if this model utilizes insight, and the answer is yes, depending on the client's needs. Some clients already have an enormous amount of insight and are stuck anyway, and other clients need to make a shift in their assumptions in order to make lasting changes. Solution Focused clinicians find that when we challenge our clients' beliefs in order to shift them out of a box, this usually involves a certain amount of insight.

INTEGRATION ISSUES

Understanding your success.

As you begin to think about your current clients and what relationship they have to each goal, you will understand why some tasks have worked and some have not.

Doing something different.

When working with clients in the future or with current clients who are not reporting progress, this is a piece of the model that you can utilize to help you shift the client toward progress. I find these concepts most useful when I am feeling frustrated by a lack of client progress or when I find myself trying to convince my clients of something. These are both scenarios in which I review the "relationship" and typically find I have misunderstood something.

Working with multiple goals.

When working with couples and families I find it helpful to break down each goal and each person's relationship to that goal. This helps clarify and simplify what may seem like a chaotic system.

The triad.

It is important to remember that the client-therapist relationship is goal specific. These designations are not like a diagnosis in the DSM-IV. As illustrated by the above example of the client with the diagnosis of an eating disorder, she had different relationships with different goals.

The box.

The schematic of (The Box) is not limited in use to the browser-listener type relationship. Clients in the customer-seller type relationship can also be "in boxes." You can sometimes tell that a client is in a box when the solution is something he/she has already tried without success. Another type of box is when a client suggests a task or goal that you believe will truly be unsuccessful. In this case you can challenge the idea by asking what will happen when they do that task. This usually gets around to the "what" as opposed to the "how".

Shifting the relationship.

We need to be careful when we are working with a client who presents as a browser for certain goals and then makes progress. It is a mistake to assume this client is now a customer for that goal. The client made progress, because you assigned the right task and not because the client has changed his/her relationship to that goal. Clients tend to stay in the same relationship to each goal and not shift.

Exceptions

During the course of the interview clients will often mention times when the problem does not occur or is a little less severe. For example, we often hear:

> *"I wish my kid would go to school more like he did today."*

> *"I want to feel less depressed, like I was last year. "*

> *"I just wish he would treat me kinder, like it was my birthday all the time."*

> *"It was hard but I resisted the urge to drink yesterday."*

These are exceptions (Berg & Miller, 1992) to the rule, and we want to expand upon these exceptions as much as possible. Try to think of exceptions as patterns of success (rather than failure). Clients will sometimes offer spontaneous exceptions during an initial interview.

You can follow up either immediately or wait until later in the session to ask;

- You mentioned you felt a little better on Tuesday. What was different about Tuesday?
- You mentioned that your husband did not drink this past weekend. How do you explain that?

If the client does not provide you with these spontaneous exceptions, you can actively ask about those times that the problem is not a problem once you have a rich picture of the client's (goals)

- Tell me about times when small pieces of the miracle are happening already. What is different about those times?
- Tell me about those times when the problem does not happen?
- Many times people notice in between the time they make the appointment for therapy and the first session that things start to improve. What have you noticed about your situation? (Weiner-Davis, deShazer, & Gingerish, 1987)

When we ask questions about exceptions, clients begin to notice more exceptions. For a multitude of reasons we have all been trained to look for what is not working, analyze it, write books about it, and study it until we completely understand how it does not work! Working with clients to identify what is working and then building upon these successes appears to be just as productive, if not more. This is called amplifying exceptions. For some clinicians it feels like circular questioning. You can ask many questions about who is responsible, how people responded, what made somebody choose to do that and what will it take to do that again (active) or what will it take for that to happen again (passive):

Case Example: Tammy is a 10-year-old girl referred due to "insomnia."

> *THERAPIST: So, let me get this straight, you said that every now and then you do sleep through the night?*
> *CLIENT: Yep!*
> *THERAPIST: About how often does that happen?*
> *CLIENT: At least once a week.*
> *THERAPIST: So every week you are already sleeping through the night one time?*
> *CLIENT: Yep.*
> *THERAPIST: How do you do that?*
> *CLIENT: I don't know. I have tried to think about it, but I don't know how it happens.*

Random versus deliberate exceptions

The preceding dialogue is an example of a random exception. In this case Tammy takes no responsibility for sleeping through the night, nor does she have any idea how it happens. The information is still very helpful and will be utilized when we develop a task for Tammy to do between sessions. We think of random exceptions as those that appear to be acts with no explanation. The client takes no responsibility for the exception occurring. There are times, however, when we ask clients to take a closer look at these random exceptions to learn more about them. Sometimes clients are able to realize that they have been responsible for the exceptions.

Deliberate exceptions, as the name implies, are those times when clients do something that creates the exception, and they can make the connection between their actions and the exception. For example:

THERAPIST: So when are those times now that you do not drink?
CLIENT: Well, every now and then I go straight home from work.
THERAPIST: So when you go straight home from work you do not drink.
CLIENT: That's correct. In order for me to get to the bar I have to make several turns off my route home. The bar I go to is out of the way.
THERAPIST: And how do you end up going straight home?
CLIENT: I just go home. THERAPIST: Do you think about it at all or do you just end up at home?
CLIENT: Oh, I think about it a lot. I usually sit in my car for several minutes when I get out of work and wrestle with myself. Should I go home or to the bar?
THERAPIST: So when home wins, how do you do that (notice the therapist chooses to amplify the exceptions, not the failure and uses active language)?
CLIENT: I just get tough with myself.

We sometimes help our clients to realize that they are indeed playing an active role in the creation of these exceptions by positively blaming (Berg & Miller, 1992; Miller, 1993b) them. Positive blame questions tell clients they are smart, which empowers them.

THERAPIST: So when are those times that pieces of this miracle are already happening?
CLIENT: Well, the other day I did feel a little better.
THERAPIST: What was going on?
CLIENT: Well, I went for a walk, and during the walk and for about an hour after I felt better.
THERAPIST: How did you know to take a walk?
CLIENT: Well, it just seemed like a good idea.
THERAPIST: It was.

This helps to connect the actions our clients take with their feelings and their thoughts. It does not matter where clients enter the loop, whether they are motivated to take a walk and then feel better, or feel better so they take a walk. Either way clients are associating walking with feeling better.

Keep in mind that clients may not be able to identify any exceptions to their problems. This does not mean that all hope is lost and you should transfer this client to your first available colleague. The availability of exceptions is only one tool. By asking about exceptions we impose the assumption that no problem remains the same over time. Oftentimes by just asking about them in the first session clients will begin to notice them before the next session. In some cases some clients do have exceptions but they are so remote that they may not be useful to the work at hand. For example, a client that has not had a sober day in fifteen years may not fully recall what being sober is all about. We could still explore these exceptions for patterns of success that could be useful to the client today; however, we find most of the time these distant exceptions are not helpful.

INTEGRATION ISSUES

Getting comfortable with the questions. Most clinicians understand the concept of exceptions, but either gloss over them in a session or struggle with the structure of exception type questions. You may find it helpful, initially, to have a page of sample exception questions that we could take into a session for referencing if you need it.

Flexibility within the model.

There are times when a client begins a first session by saying, "I'm not sure I need to be here anymore because things have turned around since I made the appointment." When you hear something like this you can begin by asking about exceptions. You might say something like, " you are probably right. What's different to make you think you don't need to be here?"

Ask someone else.

I almost always ask other people in the system if they have noticed any exceptions. You can get creative about who you ask. On an inpatient unit you can ask other patients in a group setting. In family therapy you can ask family members about what they notice about other family members. You can call people (probation officers, teachers) on the phone during a session, especially when you are sitting with mandated clients. One worker who does mostly home based work suggested that the worker may notice change that the client isn't able or ready to notice.

Clients who return after a break.

You can also utilize exceptions when a client returns for another treatment episode. I view this as an opportunity to empower my clients and send the message that they must have been doing some things right in between treatment episodes.

Strengths Perspective.

This aspect of the model is very similar to the strengths perspective model. The idea of empowering people to realize their own strengths and what they already do well can sometimes be the life tool you give to someone. Many social service agencies and home based agencies are utilizing this model exclusively.

Practicing on yourself.

You can try an exercise of thinking about a problem you have and your own exceptions. Notice how it feels to elicit and amplify these exceptions. This will give you an idea of how powerful exceptions can be for our clients. This is certainly a piece of the model that can be integrated into any other treatment modality or protocol.

Another exercise is, at the end of the day, make yourself think about everything you did well during the day instead of all the mistakes you made. Another challenge is at staff meetings to encourage colleagues to talk about what they are doing that is working so we can all learn from each other. You will quickly realize that this paradigm shift is perhaps unnatural and profoundly powerful. If we cannot do this for ourselves, how can we know the right ques-

tions to ask our clients to elicit their exceptions?

How To Learn More

Now that you have successfully completed the article you may feel ready to start to try and apply some of these concepts to your clinical work. As you may have realized, Solution Focused concepts can be applied to a therapy session, case management, supervision, management meetings, groups and so much more. It is a different way of thinking about the relationships we have with other people and how we ask questions. If you are interested in more information you can contact: Susan Tohn at 978-443-7574 or email to: sltjao@sprynet.com for information about ordering her book, "Crossing The Bridge: Integrating Solution Focused Treatment into Clinical Practice. The NASW workshop on November 4, 2005 will be a continuation of this article, moving participants from the theoretical into skill building. The workshop will involve watching video-taped sessions as well as several role-playing opportunities for participants.

Bibliography for CE Focus article on Solution Focused Brief Treatment

Berg, I.K., & Miller, S. (1992). Working with the Problem Drinker: A Solution-Focused Approach. New York: W. W. Norton and Company.

Dawes, R. (1994). House of Cards: Psychology and Psychotherapy Built on Myth. New York: The Free Press

deShazer, S. (1985) Keys to Solutions in Brief Therapy. New York: W. W. Norton and Company.

deShazer, S. (1988) Clues: Investigating Solutions in Brief Therapy. New York: W. W. Norton and Company.

deShazer, S. (1989) Resistance Revisited. Contemporary Family Therapy, 11(4) (Winter), 227-233.

deShazer, S. (1994) Words Were Originally Magic. New York: W. W. Norton and Company.

deShazer, S. Berg, I., Lipchik, E., Nunnally, E. Molnar, A., Gingerich,W., &Weiner-Davis, M. (1986). Brief Therapy: Focused Solution-Development. Family Process (25), 207-222.

Fisher, K. (1984). Human Development: From Conception Through Adolescence. New York. W. H. Freeman and Company.

Miller, S. (1993a). The Solution Conspiracy, A Mystery in Three Installments. Journal of Strategic and Systemic Therapies, 13(1), 18-37.

Miller, S. (1993). Joint workshop with Oshlag, J. and Tohn, S. in Boston, MA.

Nyland, D., & Corsiglia, V. (1994). Becoming Solution-Forced in Brief Therapy: Remembering Something Important We Already Knew. Journal of Systemic Therapies, 13(1), 5-12.

Talmon, M. (1990). Single Session Therapy: Maximizing the Effect of the First (and Often Only) Therapeutic Encounter. San Francisco: Jossey- Bass.

Tohn, S. & Oshlag, J. (2000) Crossing The Bridge: Integrating Solution Focused Treatment into Clinical Work. Boston: Solutions Press

Tohn, S. & Oshlag, J. (1996). Solution Focused Therapy with Mandated Clients: Cooperating with the Uncooperative. In S. Miller, M. Hubble, &B. Duncan (Eds.), Handbook of Solution-Focused Brief Therapy. San Francisco: Jossey-Bass.

Walter, J., & Peller, J. (1992). Becoming Solution-Focused in Brief Therapy. New York: Brunner-Mazel.

Watzlawick, P., Weakland, J., & Fisch, R. (1974). Change: Principals of Problem Formation and Problem Resolution. New York: W. W. Norton and Company.

Weiner-Davis, M., deShazer, S., & Gingerish, W. (1987). Building on Pretreatment Change to Construct the Therapeutic Solution: An Exploratory Study. Journal of Marital and Family Therapy, 13(4), 359-363.

Solution Focused Therapy

Focus CE Course Evaluation July 2005

Please indicate whether the stated learning objectives were achieved. Participants will:

Understand and be able to apply the Solution Focused assumptions to their cases.
Achieved in full 5 4 3 2 1 Not Achieved

Be able to explain the client-therapist relationship to each goal in any particular case.
Achieved in full 5 4 3 2 1 Not Achieved

Articulate the concept of exceptions and be able to articulate examples of active and passive questions.
Achieved in full 5 4 3 2 1 Not Achieved

Please evaluate the course content:

This course expanded my knowledge and understanding of the topic.
Achieved in full 5 4 3 2 1 Not Achieved

The course material was clear and effective in its presentation.
Achieved in full 5 4 3 2 1 Not Achieved

This course was relevant to my professional work/interests.
Achieved in full 5 4 3 2 1 Not Achieved

As a result of this course, I learned new skills, interventions or concepts.
Achieved in full 5 4 3 2 1 Not Achieved

The resources/references were comprehensive and useful.
Achieved in full 5 4 3 2 1 Not Achieved

This course addressed issues of diversity and/or the social justice implications of the topic.
Achieved in full 5 4 3 2 1 Not Achieved

Please provide comments on current course and suggestions for future courses.

_____

_____

_____

_____

_____

Solution Focused Therapy

Post-Test July 2005

Answer questions 1-5 based on the following case scenario: *Janet is a 40-year-old woman suffering from a depressive episode. Her parents also struggle with depression. There is probably some history of trauma in Janet's childhood. You, as the clinician, have been using Cognitive Behavioral Therapy and Janet is reporting a decrease in sad feelings and an ability to get out of bed on some mornings. She is also learning to challenge some of her thoughts with difficulty, you wonder if something in her past is getting in her way.*

1. Applying the Solution Focused assumption "if it works, do it more" would you:
   a) Start to explore her past
   b) Stop using Cognitive Behavioral Therapy
   c) Continue using Cognitive Behavioral Therapy
   d) a and c

2. Applying the Solution Focused assumption "if it isn't broken don't fix it" would you:
   a) Stay focused on getting up in the morning
   b) Give her a trauma assessment tool
   c) Explore the childhood trauma
   d) Stop using Cognitive Behavioral Therapy and start using Narrative Therapy

3. Applying the Solution Focused assumption "change is constant" would you:
Begin a conversation about her parents
   a) Ask Janet to tell you more about her sad feelings
   b) Ask Janet to talk about how she is able to get out of bed some days
   c) Ask Janet to notice when she is feeling sad and keep a journal

4. Applying the Solution Focused assumption "you don't need to know the history of a complaint in order to resolve it" would you:
   a) Ask Janet to tell you more about her parents' depression
   b) Ask Janet to tell you what feelings she has instead of sad feelings
   c) Ask Janet to tell you more about her childhood trauma
   d) Ask Janet to tell you how she formed some of her cognitive distortions

5. Applying the Solution Focused assumption "you get what you ask for" would you:
   a) Elicit stories about what went well this week in her life
   b) Initiate a conversation about family systems theory
   c) c. Explain to Janet how depression runs in families
   d) b and c

Please answer questions 6-10 based on the following case scenario: *George and Harry have three children. Their oldest daughter, Heather, is perfect. Their middle son, John is quiet and a star athlete. Their youngest daughter, Sarah, is giving them trouble. She has never been like her older brother and sister and that has always been a positive quality until recently. Sarah just turned 13 and has decided she doesn't have to listen to the house rules or to her parents. Her grades are slipping and she is staying out past curfew. George and Harry have tried to set limits on Sarah and yell at her, but this has only made her behavior worse. George and Harry have come to you for help with Sarah. When you ask George and Harry what they want, they tell you they want the old Sarah back- the one who used to snuggle in their laps, who used to care about school, who wanted to be with the family on weekends, and who followed the house rules. When you ask Sarah what she wants, she wants her parents to respect that she is growing up and give her some space.*

6. When thinking about the parents' perspective on the goal of following rules George and Harry would be considered:
   a) Customers
   b) Browsers
   c) Visitors
   d) a and c

7. When thinking about Sarah's perspective on the goals of being respected by her parents Sarah is a:
   a) Customer
   b) Browser
   c) Visitor
   d) a and c

8. When asking the parents about what they are willing to do to change the situation would you ask:
   a) George, what do you think you can do to help Sarah turn her behavior around?
   b) Harry, why do you think Sarah is behaving this way
   c) George, what needs to happen for things to get better at your house?
   d) Harry, How can you get Heather and John to help with Sarah?

9. You want to find out from Sarah how she can get her parents to respect her and give her space, would you ask:
a. Sarah, what behavior have you been doing that is upsetting your dads?
b. Sarah what needs to happen for your dads to respect you enough to give you space?
c. Sarah what do you think you will notice about your dads that tells you they are starting to respect you?
d. B and C

10. You believe that George and Harry are in a box. Is the box:
   a) Sarah is the typical rebellious third child
   b) Sarah just needs more strict limits and then she will snap back into being her old self
   c) The other two kids need to step up and help with Sarah
   d) Sarah needs to start behaving so the school stops calling

Please answer questions 11-16 based on the following case scenario keeping in mind the concept of exceptions: *Megan comes to treatment because she recently miscarried her first child. In the first session she reports that her dad is a recovering alcoholic, who acts in very dysfunctional ways. She also tells you that her mother died a year and a half ago. She is the youngest of three sisters and they all try to help each other deal with her dad, but it mostly just ruins her day whenever she gets a phone call from one of her sisters about her dad. Her anger is starting to affect her marriage. She wants help with anger management and how to deal with her dad and sisters more effectively. She tells you that she is feeling a little better in the last week and a half.*

11. At this point in the first session should you ask:
a) More about her mother's death
b) What has been better in the last week and a half
c) Why her sisters call her
d) Why she lets the phone calls with her sister upset her

12. As you follow up on the miscarriage discussion should you ask:
a) Details about the pregnancy (how far along, was it her first, how long did it take to get pregnant)
b) Have you decided on what type of ritual you want to employ in order to remember the unborn child?
c) Are you grieving the way you would like to be grieving?
d) a and c

13. As you explore more about the relationship with her sisters would you ask:
a) How often do your sisters call you to complain about your dad?
b) Does one sister upset you more than another?
c) Does your father favor any one sister more than the others
d) Do you ever talk to your sisters and not get upset?

14. Which of the following would not be a Solution Focused question:
a) Tell me about your relationship with your mother
b) When are times that your dad doesn't aggravate you?
c) How do you explain things being better this week?
d) Are these the types of changes you would like to have happen more?

15. Which of the following questions would amplify the exceptions?
a) Have you ever told your sisters that their phone calls upset you?
b) Have you ever told your dad that he aggravates you?
c) Has your work been affected by these phone calls as well?
d) Have you ever felt like you handled a phone call in a successful way?

Complete and return Post-Test and Course Evaluation after reading the CE course in this issue of FOCUS.

A score of 80% or better is passing and we will send a certificate of completion for 1.5 CEs to you.

Name_____NASW Membership #_____

Address_____City_____State_____Zip_____

Day Phone_____Email_____

Please enclose check payable to NASW
(Sorry, credit cards not accepted for this offer.)

Members $15
Non Members $25

Send to: NASW, 14 Beacon Street #409, Boston, MA 02108