

STUDENTS' CORNER

by Insoo Kim Berg

Background Information

I am frequently asked by some of you to assist in writing your papers on Solution-Focused Therapy (SFBT) because you have chosen to concentrate on some aspects of this exciting new model that you have recently been exposed to. There are some of you who fortunately find me in office and I can frequently assist some of you. But there are other unfortunate ones that I cannot assist because I am often absent from my office for a stretch of time, mostly days but other times, for weeks at a time. In recent years, such requests seem to be on the increase. Therefore, I decided to make things easier for you and for myself by posting some commonly asked questions here. I will also offer some suggestions to those of you who want to present a small segment of SFBT model to your classes or your colleagues at work on how to distill the most important aspect of SFBT. We all are very busy nowadays and I hope this will save you and myself some precious time, while accomplishing what you decided to do.

“What led you to develop SFBT?”

I was born and educated in Korea during it's most turbulent period in recent history. Initially I began my college education in pharmacy in Korea and I came to U. S. with the intention of doing a graduate work in pharmacology and/or study of hormones. One thing led to another and shifted from natural science to studying, practicing clinical practice of psychotherapy in late '60's and early '70's. In those days, even behavioral therapy was just gaining some recognition but with skeptical eyes and of course the psychoanalytic view of man was the only predominant model. Wanting to be a good learner, I even put myself on the couch three times a week, for three years. Of course my work with clients was assumed to take a long time and I expected to settle into a long-term relationship with clients who were mostly women, occasionally couples, and some children.

I began to notice myself talking about my failures a great deal in supervision and consultation sessions, usually in the form of my own “counter-transference” issues, that is, somehow it seemed like I was always making mistakes. Even though I was not accustomed to making so many mistakes, I studied diligently, driven by a desire to be a good therapist. There were several things that I observed that forced me to question myself and the approach I was learning.

Remember that it normally took six (6) sessions just to complete the psycho-social assessment and treatment plans in those days, with lengthy history that went back to several generations. One of the most disconcerting experience was that clients would drop out of treatment even before I completed the assessment. Of course it was believed that without assessment, treatment cannot begin and it seemed as if I were always discussing my failures with my supervisor which is a really uncomfortable situation.

Then I began to notice something. Those cases that I was pretty convinced that I had failed with, because they “prematurely dropped out” by not showing up or canceling appointments, would refer their best friends, relatives or family members to me personally. Something didn't quite fit together. They must have thought that I was helpful to them in some way! How could I have possibly helped them when they dropped out of treatment even before we began! I began to doubt myself, the clients, and the theoretical frame I was learning.

[The next event had a very profound effect on my professional path.] In early '70's I participated in a study and, of course, being the novice therapist meant I had to do some grunt work in the agency. This was a study with an interesting design that was conducted at various sites: The researchers selected an arbitrary date, say, April 18th as a target date, and all new intakes conducted on this date was followed-up by an in-person interview about

their experience. One of the questions that was asked was how many sessions they came before termination and whether they met their goals. One of my tasks was to do the follow-up interviews of all the cases opened on April 18th (at the agency I worked in). It took almost a year to collect the data across the country and then the results came out. Of course, having participated in the study, I was quite curious about the outcome. The results shocked me to my core.

It showed that 90% of all clients across the country came fewer than 20 sessions! I was struck by the implication of this that perhaps others did not see, or did not care about. It seemed to explain my nagging sense of chronic failure: I was using a model that was useful to only 10% of the population! It means that 90% of the clients came fewer than 20 sessions. The study further showed that 80% of the intakes conducted on April 18th came 7 sessions or less! There has to be a better fit between what clients want and need and how therapists conceptualize the helping process.

It led me to search for a sensible model that applied to my clients who wanted to solve problems right away, not next month or next year. Overwhelmed with life, they were looking for ways to reduce their frustrations and to get along with each other and wanted their lives to be a little more satisfying. Reasonable things to ask for, I thought. My clients seemed hard working, basically decent people who told like it was without beating around the bush. But I realized that I did not know how to be helpful and useful to them in a practical, efficient manner. My search led me to the meager literature on brief therapy and was I surprised to discover that there were some studies coming out of child guidance movement that pointed toward working with the families of difficult and disturbed children. Family therapy was just coming to maturity and there was lots of energy and innovation. I terminated my own analysis prematurely (against the advice of my analyst) and commuted to Chicago to attend postgraduate training in Family Therapy.

The training turned out to be a psychoanalytically oriented family therapy. One of the criteria for graduation was to keep a family in treatment for a year! I barely managed to meet the criteria of success, barely keeping a family in treatment for a year. This led me to Palo Alto, where the Mental Research Institute is located. The Brief Therapy model developed by Watzlawick, Weakland, Fisch at their Brief Therapy Center seemed to make sense and I was very drawn to it because of its pragmatic approach.

Beginning of the BFTC Team

When Steve de Shazer joined the team in Milwaukee, the informal, loosely formed team became energized and we began to talk about our dream of establishing “the MRI of the Midwest” and the team of five set out to study the most effective, efficient ways to help clients. We experimented with a variety of approaches and argued a great deal about what made sense to us. The team also struggled with many, many issues that we never thought existed but somehow we were determined to make it. We opened our own offices in 1978 with a small bank loan, using our modest house as a collateral and our office was equipped with a one-way mirror, a telephone hookup between therapy and observation rooms, a videotape recorder, and a team of observers. We deliberately selected the team members with diversity in mind, personal background and academic disciplines which included, philosophers, educators, sociologists, physicians, linguists, even engineers, along with usual mental health professionals. We called our training and research group: Brief Family Therapy Center.

How did the ideas of Solution-Focused Brief Therapy begin to emerge?

The first discovery we made were “exceptions” to problems — somewhere in the very early ‘80’s. We were shocked to discover that there were times in clients’ troubled lives, when the problem was either a little less severe or absent. This discovery led us to observe carefully and eventually we learned when the clients repeated exceptions to problems, this would eventually lead either to the problem disappearing or the client redefining what was a problem, I.E., the problem is no longer a problem for them.

Along the way came the Miracle Question in 1984 when we discovered that clients can have, with help from the therapist, a clear sense of how they want their life to be different. When this vision is very realistic, achievable,

concrete, measurable, is important to the client, the therapy moves rather rapidly. We also learned over the years that the way we phrase the Miracle Question made a difference in shaping the answer.

Next came scaling questions, which are described as a self-accessed assessment tool, that is, clients assess their own situations in terms of progress, seriousness, determination, hopefulness, and all of these can form the basis for a discussion by using a 0 - 10 scale.

In order to generate money to pay rent, telephone, electricity, and assistance in office, we began to offer training opportunities from the beginning of BFTC in 1978. We believe this activity of trying to explain to someone what we were doing was a tremendously important element in our development. As someone says, "studying results in learning; teaching results in knowing." In order to teach, we had to know and as we knew, we learned more. Also through the publication of our work (starting with Steve de Shazer's *Patterns of Brief Family Therapy*, Guilford Press, 1981) we got lots of feedback on what and how we were doing.

The model, which began as a clinical model in an outpatient setting, has since been adapted and applied to numerous settings with a variety of populations and problems: drug and alcohol abuse, domestic violence, school problems, chronic mentally illness, case management, and child protection investigations, corrections, criminal justice, prison population, social services, residential treatment programs. This model is practiced around the world (Berg & Dolan, Norton, '00) now and has a wide appeal among practitioners because of its simple, practical, infinitely respectful approach to working with people.

What is unique about SFBT?

Developed from an inductive process and often described as coming from a "different paradigm," SFBT differs from problem-solving approaches in its philosophy and techniques. We believe that the "problem-solving" paradigm which is commonly accepted in most treatment models can be described as a medical model. Contrasted with this, SFBT can be described as solution-building approach. These two activities are distinctively different and have tremendous implications for clinical practice. (DeJong & Berg, *Interviewing for Solutions*, Brooks/Cole, 1998).

What separates SFBT is the premise that the future is created and negotiated, and not a slave of the past events in a person's life, therefore, in spite of past traumatic events, a person can negotiate and implement many useful steps that are likely to lead him/her to a more satisfying life. The second assumption is that the client has all the resources, skills, and knowledge to make their life better, if they decide that this is good for them and that s/he wants things to be better for him/her. Small change can lead to making a big difference in the future. There are many more assumptions that drive the model and variety of techniques that express these assumptions. (See DeJong & Berg (1998), de Shazer (1995), Berg (1994), and many others.

Described as minimalist and as fitting within social constructionism, SFBT pays a great deal of attention to language as the primary tool we have and how language shapes what kind of conversation a therapist will have with his/her client. It is rooted in the belief that language shapes and molds the perception of reality and therefore, some conversations are more useful than others. That is conversations are useful in shaping and determining what kind of life the client wants, what the client knows how to do toward getting their desired outcome, and helping the client find ways to do it.

What and How to present the key concepts of SFBT in limited time I have for class presentation?

There are a number of topics you can select to present. Common questions students raise are: How do you work with handicapped children using this model? Does this model work with drug addicts and alcoholics? What about sexually abused children? How about working with couples? What about jealousy? Depression? Chronic

and persistent mental illness? Domestic violence offenders? You get the picture.

These kinds of questions come from a traditional medical model that assumes that each problem category has its own unique and separate treatment approaches, that is, solutions must match the problem. Thus, it is commonly believed that finer diagnosis and assessment will lead to a better selection of solutions that will match the problem. DeJong & Berg (1998, Brooks/Cole) describes this as a “problem-solving” paradigm. SFBT assumes that “building solutions” is more effective and respectful of what the client brings to the relationship. Thus building on this client’s existing strengths and resources to find solutions (past and current successes, however small and seem irrelevant) and efficient way to collaborate with clients.

For further information, I would suggest you look at our reference list on this website.

How do I present this model to my class?

Obviously you want to select the most prominent feature of the model and I suggest the following ideas and techniques.

Experiential Exercise I:

1. Ask the class to form into a dyads. One of the dyads will play the most difficult client they heard about or they had actually encountered in recent times. The other person is the counselor, therapist, or social worker trying to interview the client with lots of problems in their usual approach. Ask the dyad to carry on a normal interview for 5 - 10 minutes. Ask them to stop. No discussion or debriefing.
2. This time, the same pair, same client, and same problem. Ask the student who played the client to turn his/her back toward the writing board so that the client cannot see the questions the practitioner is asking. The questions are only visible to the practitioner. Then the counselor/worker asks the following questions you posted on the writing board or on overhead. The dyad spends 5-10 minutes.

Solution-Building Questions

1. Tell me about the times when this problem is a little bit better?
2. Tell me about the most times when this happened?
3. How did you make this happen? What else?
4. What are you doing differently during those times when things are a little bit better?
5. What would your best friend (mother, child, etc) tell you when things are going a little bit better for you?
6. Ask the group to stop. Now ask those who played the client to describe their experiences. What were the differences between the two conversations. Which went better for the client? Which felt more cooperative? Which would you prefer as a client? What would the group say were the differences between the two interviews? Which conversation was more empowering? If you were a client which conversation would you prefer? Then ask the interviewer the same questions. Which felt better? Which felt collaborative? How was your reaction to your client different in the two dialogues?
7. Summarize the differences you have heard from the group and point out that the later questions were from SFBT and it is an example of how different interviewing can be. You have just described and demonstrated exceptions to problems. The entire exercise can take 20 - 30 minutes.

8. The first conversation usually comes from the expert position of a practitioner who must “assess” the client who has this or that kind of problem. Which way would you like to practice?

Exceptions to Problem:

The above exercise not only points out the differences between two paradigms but also the basic assumptions we make about the people we work with. Listening for exceptions takes lots of training because in everyday life, we tend to pay more attention to problems than to solutions or small successes. SFBT contends that all problems have exceptions, that is, a person could have lost his/her temper but somehow managed to do it slower, less intensely, or even decided to walk out of the house and not yell at the child. I met a mother who explained that she locked herself in the bathroom so that she could control herself enough not to slap her child as she normally does! What an amazing desire and ability to control herself from doing harm to her child? When we ask for details about such creative ways to change her behavior, the client becomes amazed at her own ability to control her temper. Also, her desire to be a good parent becomes more vivid to her. The next step is to repeat this small success.

Scaling Questions as a Self-Assessment Tool

On a scale of 1 to 10, where 1 stands for how badly you felt when you first decided to come and talk to me today and 10 stands for how you will feel like you don't need to come to see me anymore, where would you say you are at right now?

How did you manage to get all the way up to 2? That's 100% improvement from the day you called. How did you do it?

What would it take you to move up 1 point higher?

When you move up 1 point higher, what would your best friend (mother, boyfriend, etc) notice that will tell him/her that you are doing a little bit better?

You can use scaling questions to ask about a variety of issues and concerns such as: safety issues, how hopeful, how determined, confidence, desire, sadness, proud, and host of other topics that will help the client to decide his/her own appraisal of situations.

Coping Questions:

You have been through a lot the last couple of month. How in the world have you coped with so much, while going to school (holding down your job, taking care of the children, getting up in the morning, etc. that the client is actually doing)?

What do you suppose your best friends (family, daughter, co-workers, etc.) would say how you've been doing it?

How did you know that “keeping low” was the best way to cope with such a “terribly oppressive” situation you were in? What did you know about your job that told you that it was the best policy to keep your job until you saved enough money?

When you are so depressed, like you are describing, how do you manage to keep doing all these things you've been doing? It is amazing.

The above questions and variations on the above questions convey to your client that you are “admiring” your client while commiserating at the same time at the persistence and strength he/she shows by keep “hanging in there” in spite of what he/she considers to be an overwhelming task. By answering these and other similar

strength discovering questions, the client him/herself explains their strong motivation, determination, and will to “make it.”

Miracle Question

This question requires the biggest departure for most clinicians trained in traditional therapy models because it sounds “nonscientific” and they are afraid they may sound foolish to the client by asking such question. However, this question has been used thousands and thousands of times all over the world, and experienced clinicians believe this is one of the most useful questions because it helps the client paint a detailed picture of his/her desirable state of life - thus describing their goal for the contact or their view of what will make their life a little bit better off. There are numerous descriptions of this question and its application in every conceivable human interaction that I will not go into the details of this useful question, but suffice it to say that these questions have been used in all sorts of settings and variety of clinical and non-clinical populations. For further information on this question, see the column written by Steve de Shazer on this website.

Conclusion

I hope this bulletin titled For Students Only is useful to you. This information is designed to be a supplement to your reading and also the classroom lectures from your professors and instructors. Please feel free to adapt and change to suit your needs and the time limits of your