Problem to Solution

Brief Therapy with Individuals and Families

Revised and Expanded Edition

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THE AUTHORS

Evan George, Chris Iveson and Harvey Ratner are the co-founders of the Brief Therapy Practice. The Practice is a training, consulting and clinical organisation based in London. Established in 1989 it now offers Europe's largest training programme in solution focused brief therapy.

The core (and passionate) interest of the authors remains the development of solution focused thinking and its flexible application in the widest range of contexts.

Brief Therapy Practice

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FOREWORD TO THE FIRST EDITION

By Steve de Shazer

I have a confession to make: When I first was given this book, I was curious and I started reading it with interest until I got to the table of contents which quickly sent me into Chapter One where, upon seeing the top of page 2, I quit. I then procrastinated, postponing my reading of it as long as I possibly could. I prolonged this procrastination until it was no longer viable, i.e., I might get caught out.

Frankly, I was afraid that Evan George, Chris Iveson and Harvey Ratner, whom I had just met briefly, had developed a 'readers' digest' version or a 'cook book' or (my worst nightmare) a statement, a manifesto about the right way to do brief therapy. Perhaps surprisingly, I did not worry about whether or not they had 'understood' my work and the work of my colleagues. After all, even a misunderstanding might turn out to be clinically useful.

Nagged and cajoled finally into reading PROBLEM TO SOLUTION, I was amazed to find evidence in Chapter One that they had gotten the idea. And, in Chapter Two (and subsequent chapters), I saw that not only had they got the idea, but they were able to use it to work with their clients in a useful way. I found Chapter Three (*now Chapter Four*) involved the kind of situation (therapist/team with a statutory case) that many therapists find 'difficult'. But they were not put off stride; they did not pull a Lestrade and chase after red-herrings. Instead, they listened to the client, found out what she wanted and worked with her toward getting it. This is, of course, the core of solution focused brief therapy.

So, I find that I can recommend this book; particularly to busy therapists who do not have the luxury of time and for those therapists who want a place to start exploring solution focused brief therapy. It is not a pastiche, not just a re-packaging of my work. Rather, it is an original contribution: PROBLEM TO SOLUTION can stand on its own two feet.

INTRODUCTION

This book describes an approach to counselling and consultation known as Solution Focused Brief Therapy. It was developed by Steve de Shazer, Insoo Kim Berg and their colleagues at the Brief Family Therapy Center in Milwaukee in the early 1980s.

Its first known use in the UK was by the authors while working together as a team in an NHS child, family and adult psychiatric clinic in central London. In 1990 the first edition of this book was published; it described the approach as it was viewed at the time and included a number of case descriptions to illustrate its application.

It is now almost ten years since the first edition. In that time the authors have developed the Brief Therapy Practice (an independent therapy, training and consultation organisation) into the first solution focused brief therapy centre in the UK and it is now the biggest provider of solution focused brief therapy training in Europe. More significantly, during this time solution focused brief therapy has moved from the margins of professional practice to a much more central position, having become the approach of first resort in many agencies.

Solution Focused Brief Therapy has altered in many significant ways since the first edition was published. Gale Miller, a sociologist who observed the Milwaukee clinic's progress over a 13-year period, has gone so far as to describe two complete stages in the development of the approach (Miller, 1997), and in his terms the approach described in our first edition would be fairly representative of what he calls the first stage. We are less inclined to see the development of the approach as clearly definable 'stages' in the way he sees it; for us it has been a gradual expansion of the model with different elements of the original approach being emphasised in different ways.

Our aim in publishing a revised edition of the book is to take stock of the changes in our own 'version' of solution focused brief therapy. We are more than happy to reproduce the clinical case chapters from the first edition. These were cases seen at the Marlborough Family Service (the NHS 'clinic' of the text) where the authors were working at the time. Our approach has altered over the years, but what is being illustrated in these chapters is in many ways the bedrock of all solution focused practice.

For this new edition we have substantially re-written the first chapter so that the model we are describing reflects what we practice and teach today. We then add a further chapter which specifically details the

changes in thinking and practice that we can identify as we look back over the last decade. Then after the four original case chapters, we have added a further one centred on work we have done in the last two years in a mixed comprehensive school in central London. The chapter 'Other Clinical Applications' incorporates material from the first edition and is much expanded. As before, clients' names and some details have been changed to protect their confidentiality.

Finally, there are appendices relating to research findings and further reading. Solution Focused Brief Therapy was a new phenomenon in the field of counselling when we first wrote about it; today it has aged sufficiently for us to review the growing body of research that is evidence of the effectiveness of the approach and therefore, we believe, an endorsement of our original enthusiasm and desire to 'spread the word'.

The chapter on the project in the school is only used as an example of our current practice. We see a mixture of clients, some self-referred and fee-paying, others referred through social services, education departments, hospitals and so on. We are also engaged in other projects in the community, such as work with the duty team of a local authority's children and families department where we have used solution focused brief therapy to help prevent the need for young people to be accommodated away from home in times of crisis. We have always seen it as essential to look at ways to bring solution focused thinking into situations where the workers concerned are not working as 'pure' therapists, for example, in statutory contexts. We will continue to expand our use of the approach and thereby hope to contribute to its development and application in the 'difficult' areas that Steve de Shazer refers to in his foreword to the first edition.

CHAPTER ONE

A CO-OPERATIVE THERAPY

FROM PROBLEMS AS RULES TO EXCEPTIONS AS SOLUTIONS

A simple example from de Shazer's writing illustrates the essence of the solution focused approach. He describes a client who stated that his problem was that he was always depressed. Asked then how he knew he was depressed (because, if he was always depressed, then that would be 'normal' to him), he said that there were times when he felt less depressed. These occasions were, for him, the exceptions that proved the rule, of always being depressed. de Shazer then focused on what the client was doing when he felt less depressed. Problems and the behaviours associated with them are often seen by clients as static situations in which the 'same damn thing' keeps happening: the same damn thing appears to take on the quality of a rule of life. What happens in the client's life when the problem isn't happening (when, for example, he feels less depressed) can therefore be called not 'the exception that proves the rule' but 'the exception to the rule'. It is these exceptions that can then be used to construct solution behaviours: the exceptions themselves forming the basis of the solution, so that clients may only need to do more of what they are already doing in order to solve the problem.

What de Shazer discovered was that by amplifying the 'solution' pattern of behaviours, they began to outweigh the problem patterns. The depressed client did more and more of the things that he did when he was less depressed, and consequently he experienced himself as being less and less depressed. It is as if solution behaviours and thoughts are discontinuous or mutually exclusive to problem behaviours and thoughts.

Brief therapists have for a long time pointed out the importance of a client 'doing something different' because, from a systemic point of view, if one significant person in a system begins to change, the rest of the system will have to change in relation to that person, and, therefore, only a small change may be necessary to set the ball rolling.

However, if in most cases clients like the depressed man are already performing solution behaviours, why do these not have an effect? How is it that the very things that are dismissed at one moment as being the exceptions that *prove* the rule can later become the exceptions that

undermine the rule?

Change, it is argued, can arise from either a difference in how a person views his or her world or by a person doing something different, or both. It is obvious that our behaviour is influenced by our beliefs, themselves the result of family and wider social experiences over time. It is also obvious that our beliefs are changed by our experience. If someone dislikes traffic wardens then experiencing a traffic warden as helpful one day might either be seen as the exception which proves the rule or as new evidence which will alter that belief. Why that particular warden on that particular day will make a difference to our previous beliefs and behaviour is a difficult question. So the man who is depressed doesn't see his solution behaviours as being solutions - he believes they simply emphasise the extent of his problem ('prove the rule'). But once the therapist describes them as successes ('exceptions to the rule') the client may start to see his world differently; or, if the client starts to do more of what he is saying is good for him, he may come to believe that he does indeed hold the key to his own solution. The therapeutic endeavour is a search for solutions. A person may need to meet several helpful traffic wardens before changing his or her view of them, just as the therapist needs to help the client identify as many thoughts, feelings and behaviours that are different from the usual, so that they actually start to make a difference.

An important concept in solution focused therapy, based on the Buddhist idea of the illusion of stability, is that change is happening all the time. For clients who feel dominated by a problem that won't go away this is a hard idea to grasp: for them, it is as if time has stood still. But it is an idea that maintains the therapist's optimism for the future, and it has often been said that a function of any therapist is to be a source of hope to clients.

THE TASK OF THE THERAPIST

The consequence of the search for solutions, for the 'difference that will make a difference' (Bateson, 1972), is that in a typical solution-focused interview there is minimal focus on problems: problem-free and solution talk is encouraged wherever possible to enable clients to reach a position of belief in their ability to change their lives.

It is, then, the responsibility of the therapist to guide the conversations in the session towards solution talk. As Ben Furman says, he or she acts as 'Head Solution Talker', creating a way of talking that is more likely to lead to change.

According to Hoffman, the therapist comes into the family 'without

any definition of pathology, without any idea about what dysfunctional structures to look for, and without any set idea about what should or should not change' (Hoffman, 1990). The task of the therapist is to join with the family to co-evolve a therapist-family system through which change can occur. The notion of co-evolution derives from second-order cybernetics, in which the observing system of therapist plus team is included in any description of what is thought to be happening in the family, to make it clear that the family is not some objective entity to be acted upon in the therapy situation (first order cybernetics). According to Cecchin (Cecchin, 1987), the stance the therapist needs to take is that of being curious about the family's beliefs and behaviours. The therapist's curiosity is conveyed to the family, who in turn develop a curiosity about alternative descriptions or readings of their story, and consequently can develop new ideas or behaviours. A solution focused therapist has a more explicit interest in change than Cecchin or Hoffman and, as an advocate for change, will focus on solution as a deliberate act to guide the family towards changing. However, it is not an authoritarian act on the part of the therapist: he or she believes change will come about, but is not telling the family *how* to change; he or she merely 'flags' what appear to be solution thoughts and behaviours because the family, while thinking 'problem' (and perhaps encouraged to do so by other professionals and friends), is unable to notice the significance of the exceptions.

SOLUTION TALK

The primary activity of the solution focused brief therapist is, as in most therapies, to ask questions. The particular types of questions belong to two main categories: future-oriented questions that look to identify how the client will know that their problem has been solved, and present- and past-oriented questions that seek to locate successes in the present and the past that are signs of the client's ability to solve their problems.

Examples of future-oriented questions might be:

How will you know things are better? What will you be doing differently then?

If you two weren't arguing so much in future, how would you know that it's not just temporary but that it will last?

How would your son know that you are not letting drink get in the way of your relationship with him?

When you are less depressed, what is your partner going to see you doing differently?

The last two questions incorporate a technique derived from family therapy, that of engaging a person in speculating as to what the perspective of a significant other might be. These 'other person perspective' questions help a client to see themselves through the eyes of someone who knows them, and thus to develop a richer description of their possibilities.

Examples of past-oriented questions that explore possible successes are:

> What did you do that was good for you in the last week?
> How did you do that?
> What did your mother see you doing?

We have found that the work of Michael White is rich in change-oriented questions, for example (White and Epston, 1990):

> Can you recall an occasion when you could have given in to the problem but didn't?
> What do you think your sister could have noticed about how your relationship coped on this occasion that could have been surprising to her?
> What does this change tell you (or me) about you as a person?

THE STAGES OF THERAPY: THE FIRST SESSION

> 'The purpose of the first session is to establish rapport between client and therapist, focus the client positively toward solution, and establish goals' (Lipchik and de Shazer, 1986).

de Shazer and his colleagues have developed a number of steps to successful therapy, all of which are likely to be taken in the first session. The first session then is a blueprint for the entire therapy and, in our version, consists of six basic areas for exploration with the client:

1. 'Problem-free' talk: building rapport and locating strengths.
2. What the client wants to achieve from the session or the therapy as a whole.
3. A description of a future without the problem.
4. Exceptions: what the client is already doing to move towards their preferred future, and how they are coping.
5. Scales: evaluating the degree of progress already made and identifying future signs of progress.
6. Constructive feedback regarding the client's skills; offering a suggestion (usually that they observe signs of progress).

This is, of course, a rather thin account of what the therapist will focus on in a typical first session. It by no means does justice to the extent of the therapist's activities. For example, although the session ends with the worker giving the client feedback, they will most likely have taken a short break from the session in order to think about what feedback to give. Furthermore, constructive comments are not reserved only to be given at the end of a session: throughout every solution focused meeting the worker will be searching for and highlighting the client's strengths and resources, and consequently the giving of compliments is a constant theme.

Problem-free talk

Many counselling approaches will begin with a rapport-building 'getting to know you' phase. In solution focused therapy we are specifically interested in successful areas of clients' lives, at home, work, school and elsewhere. This enquiry usually lasts no longer than five minutes, but it enables the worker to convey an interest in the client as a *person* rather than as a walking problem.

Preferred outcome to the session

The 'getting down to business' part of the work begins with asking the client what they hope they might gain from attending the session:

> What are your best hopes for this meeting?
> Let's say this session turns out to be useful to you. How will you know?

In most cases the client's first response will be a statement of the problem that has brought them to therapy. The therapist will listen respectfully to this, and acknowledge the trouble it is causing the client. But the therapist will avoid asking detailed questions about the problem, moving instead, as quickly as possible, to checking again what the client's preferred outcome would be.

> It sounds like it's been very tough for you lately. So, in coming here today, how will you know that this meeting will have made a difference for you?

Sometimes a client will say that what they are hoping for is 'advice' on what to do. In solution focused therapy we seek to avoid giving advice, at least in a way that would seem to impose solutions from an expert position. So our aim will be, ultimately, to elicit from the client their way of doing things well so that we can then 'advise' them to do more of it in future. Nevertheless, it is important that the client's wishes are taken

seriously:

> If you leave here today feeling that you received good advice, how will you know? What will you be doing differently then?

If the client remains unclear about what they are hoping to get from the session, it may be because they have been sent; this is particularly likely to be the case in statutory situations.

> What do you think that those who are most concerned about you are hoping that you will get from coming here today? What will they see you doing that will tell them it's been useful?

The worker will ask as many questions as necessary about this in order to establish that there is a positive outcome to the session that the *client* wants - even if that is only to do just enough to get others off their backs!

A future when the problem is solved

There are a variety of questions that workers can draw on to help clients clarify the future they hope to have when the problem is solved. The one most used by solution focused therapists is known as the 'Miracle Question':

de Shazer: So, I have a somewhat strange question, but, uh, suppose that ah… when you go home tonight and you go to bed and you go to sleep, a miracle happens. OK? And the problem that brings you in here is solved.

Client: Mm hm.

dS But you can't know it.

C Mm hm.

dS 'cause it happens while you are sleeping.

C OK.

dS OK?

C All right.

dS So, when you wake up tomorrow morning, what will you notice, what will give you the clues that maybe a miracle has happened? (de Shazer, 1994)

The therapist will seek to draw out the client's vision of the future in as much small, concrete detail as possible. Many clients will answer in terms of feelings they hope to have, and will refer to problem behaviours they hope will have ceased. The solution focused worker will encourage the client to translate feeling statements into behavioural expressions, and will focus on positive descriptions of what the client will be doing, rather than what they will not be doing:

> So, when you are feeling happier, what will you be doing then? After the miracle has happened and you and your partner are arguing less, what will you be doing instead?

The perspective of significant others will be invoked to aid this process of clarification:

> What will your partner (or child, or social worker, etc.) see you doing so that they will know a miracle has happened?

Exceptions

With a picture of the preferred future drawn as carefully as possible, it is a simple step to enquire when, in the recent past, aspects, however small, of the miracle scenario have already been happening. In fact, in a large majority of cases clients will spontaneously elicit such memories themselves in the course of describing their preferred future. Again, the worker will aim to draw out as much behavioural detail as possible:

> What are the signs, however small, that this miracle is already starting to happen?
> When was the last time you were able to ...? (Here, a specific behaviour will be referred to). How did you do that?
> If your partner was here now, when would they say was the last time you managed to do that? What would they say they saw you do?

Those positive behaviours that the client says are already happening now are evidence of what the Milwaukee team referred to as 'pre-treatment change' (Weiner-Davis et al, 1987). They developed the idea of inviting the client, for example during the initial telephone call or in the letter offering the appointment, to observe any changes or differences prior to the first session. They found that a significant number of clients then report changes that, of course, can be ascribed to the client's own resources rather than to the effect of therapy. Being able to locate change outside the therapy sessions is a constant goal of the therapist.

Where the client reports few or no positive developments, the worker will enquire how the client has managed to *cope* with life and how they have managed to stop things from getting worse. Again, the aim will be to draw out as much specific detail as possible.

In general, just as the more clearly the client is able to describe their preferred future, the more likely it is that they will want to make the effort to achieve it; so, the more exceptions there are to a problem the quicker a solution will be found.

Scale questions

The practitioner is now in a position to assess with the client the degree of progress already made towards the realisation of their preferred future. There are many ways to use scale questions to this effect, but a typical method is as follows:

> Let us say that 10 represents the day after the miracle has happened and 0 the worst things could possibly be. Where, between 0 and 10, would you say you are right now?

In some of the cases described in this book, a reverse scale of 0 representing the time when the problem is totally solved and 10 representing the time when things were at their worst is used instead.

There are many possible benefits arising from the use of these questions. They are, firstly, a simple means to *assess* progress from session to session. They can be used to ask someone where on the scale they would feel would be 'good enough' for them: frequently this is put at 7 or 8, and therefore the work can terminate at that point. Secondly, in initial sessions it is not uncommon for clients to have an all or nothing attitude: either they are to be totally dominated by the problem ('it always/never happens that ...') or they want the miracle to happen and they want it now! The scale shows them that, generally, life is on a continuum. The average initial session rating is about 3. This enables the worker to enquire how come they are at 3 and not at 0: this leads to the detailing of *exceptions* that are already happening in the client's life. Thereafter, the client can be asked how they will know they have reached *one step* up on the scale, to 4 in this example. The therapist will emphasise that what is being asked for is a description of a *small* step; if fitting, clients can be asked about half points!

Any number of scales can be used. A common example, after assessing a client's general progress towards their preferred future, is to ask what their *confidence* is:

> If 10 represents your total confidence that you will reach the 'good enough' point on the scale, and 0 represents that you don't think there's any chance, where, between 0 and 10, would you say your confidence is right now? How come? What will need to be different for your confidence to be one point higher?

Clients can be asked where on the scales they think significant others would place them; if those others are present they can be asked their views, and it is usually the case that concerned others (parents, partners, etc.) will rate the client's progress slightly higher than the client rates

themselves.

In a typical first session, scale questions will represent the last part of actual interviewing.

The 'break': working out what feedback to give

All solution focused sessions will end with constructive feedback to the client and possibly the suggestion of something the client might do or, more usually, look out for after the session. The feedback does not need to take long but the choice of words is very important and therefore a break from the session can give the worker the opportunity to plan what they are going to say. If circumstances allow, the therapist will leave the room to do this.

Compliments flow naturally from a consideration of clients' strengths, and are therefore shared with the client throughout the session. The final feedback may need to be no more than a summary or repetition of compliments already given. Attention is paid to using the client's own words to describe their qualities: the more the client hears things described in their terms the more likely it is that they will feel not only that the therapist has listened carefully to them but also that he or she is not patronising them.

Feedback and suggestion

The session ends with the worker sharing their views with the client. Attention is paid to the client's responses as the feedback is given, so that the therapist can evaluate if the client believes they have been heard correctly: nods of the head are a good sign!

The client is then asked if they want to have a further session. If the answer is 'yes' they are asked when they would like to come back: in general, a longer rather than a shorter gap is preferred so that the client has more time to make and notice changes.

If a suggestion is offered to the client it is usually that the client continue the process begun in the session of looking out for changes and progress:

> Notice any improvements
> Notice what you are doing as you move up the scale
> Notice what you are doing to resist the urge to drink to excess (or gamble, be violent, steal, argue with the teacher, etc.)

In some situations it is possible to suggest something for the client to do. At its simplest this could be merely to invite the client to do more of what they have learned works best for them in moving them forward.

There are a number of more complicated suggestions that can be made; in general the worker should be wary of being too directive, in case the client 'forgets' to do what they've been told and the client-therapist rapport suffers. Some examples of different 'tasks' will be found in the cases discussed in later chapters.