Family Preservation

A Brief Therapy Workbook

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She is an expert in working with multi-problem families, drug and alcohol abusers, the homeless and delinquent adolescents and their families.

Acknowledgments

Insoo Kim Berg showed me *Family Preservation* a year ago. She has since rewritten it. With the aid of the editing skills of Jeanne Sullivan, Kath Walker and especially Evan George, the book was reshaped, bringing out its special relevance to the United Kingdom. My thanks to all of them for making this edition possible.

Richard Gollner, Publisher
London, May 1991

Foreword

Everybody knows a lot about families since we all grew up in one. Yet the more one knows, the less one seems to know. Every family seems the same, yet they are all different. The family is a wonderful institution, the source of so much pride and yet so much shame; strengthening, yet draining; nurturing, yet demanding; easy to understand, yet confusing.

Welcome to the exciting, energising, painful and exhausting work with families: FBS. This work will be the most meaningful and challenging you have ever done, and will ever do. It will stretch your mind, help you discover skills and strengths you did not know you had. You will love the work and curse the problems. And I assure you it will be anything but boring.

You will touch the lives of the families you work with in a way that is not possible to measure. The impact you will make on your clients may not be obvious immediately but your clients will feel empowered for having travelled a short distance of their lives with you as their guide.

This manual is designed to ease your pain a little, to increase your excitement about your work, and to help you grow through your discovery of the amazing human spirit, in both yourself and the client.

This book is written to be your guide as you wade through the mountain of information about the families you work with. It is written in a step-by-step fashion, in simple language with very little jargon and few technical terms. The case examples are all real, and I have been involved in all of them, either directly or indirectly. There is no mystery to "therapy": when you follow these steps you are doing "therapy" and providing treatment to families, even though you may be working with only one person in the family.

I am grateful to all the families who taught me about their incredible strengths and resilience in the midst of pain and suffering.

A special thanks to my colleagues: Steve de Shazer and Larry Hopwood who have been generous with their help and patience.

Insoo Kim Berg
Milwaukee, Wisconsin, April, 1991

Introduction

The history of work in the field of child protection has been punctuated by tragedies, from Mary Ellen Wilson in New York in the last century, through John O'Neil, Maria Colwell, Tyra Henry, Jasmine Beckford and Kimberley Carlile. There have of course been many more children who have died at the hands of their adult carers, but these particular children, among a number of others, are remembered because their deaths led to pressure of public opinion for something to be done. And things have been done. But without exception the response has been legalistic and administrative. New laws have been passed, old laws have been changed. Guidelines for inter-disciplinary cooperation have been formulated and refined, and refined again. We have Case Conferences, Child Protection Registers and Key Workers. A great deal of thought, and some research, has gone into identifying "risk factors", and recently guidelines for assessment have been published (DOH 1988). There must be no denying that this work has been useful. Indeed, there is some evidence that lives are being saved. But none of this has helped workers allocated child protection cases, to know what to do and what not to do to bring about change in the relationship between the child or children in question and the family.

The Children Act 1989, centred as it is on the idea of parents and professionals working together, promised a new beginning. But, unless the professionals involved have a workable model of change, all they will be bringing to the partnership will be material help, resources, facilities, respite care and the like. While such help is important and necessary to bring about change in the complex family problems which typify many of the families that the helper will encounter in this work, it is not sufficient.

The expansion of knowledge about families where child abuse or neglect has occurred has served to challenge the old stereotypes which left abuse in middle-class, apparently respectable families largely unrecognised, and now workers hesitate, rightly, to generalise about so-called abusive families. And yet despite the diversity of family type, most professionals agree that finding ways of working with families who are angry and feel disempowered, intruded upon, "unmotivated" and "resistant", is a key practice issue. Models of change, in order to have any validity for workers in this field, must give professionals clear ideas about how to work with families who do not want to be worked with. Insoo Kim Berg's ideas about developing cooperation more than fit the bill, and indeed in her book she suggests specific interventions to help the worker to cooperate with the family's "unique way of cooperating" (de Shazer 1984). So the basic criterion for judging a model in this field, is more than

fulfiled. But beyond this the solution focused model which she applies is empowering of clients and optimistic of outlook, both vital factors in an area of work where clients and workers alike can be overwhelmed by the weight of pressure, and where both can be left feeling hopeless and useless.

For most British readers one major difference of case-management is presented. The context within which the work that Insoo Kim Berg describes separates the primary child protection and treatment functions, leaving the Family Based worker free to concentrate primarily on the question of change, secure in the knowledge that child protection, in its most limited sense, is being handled by another agency. The potential for creativity of this model has been described elsewhere (Asen et al. 1989), but the majority of child protection workers in Britain have the double task of protection and treatment to perform. Not only must every transaction with the family be evaluated in terms of "Is this different?", "Is this useful?", but also in terms of "Could this be dangerous?" or "Is this evidence of underlying pathology emerging?" The worker is expected to look forwards and backwards at the same time, to empower parents while holding the statutory authority. Even when workers train themselves to be virtuosi in the art of hat-changing, the results can be baffling for the client and undermining for the worker who is trying to use every ounce of effort to move forwards, while having to watch out behind. It is hoped that one of the benefits of this book will be to encourage managers to think again about the way in which services are organised. However, for the present, workers in Britain will need to continue to develop their positional agility, holding both the child protection and the treatment roles continuously and simultaneously in their minds and perhaps discovering new and different applications for Insoo Kim Berg's ideas about the use of split messages.

Insoo Kim Berg's work will change practice and will open up new solutions for child protection workers who have become dissatisfied with a monitoring role, and who are searching for ways to develop cooperation with their clients as a basis for building safety for children.

Evan George
Brief Therapy Practice
London, April 1991

One
WHAT IS FAMILY BASED SERVICE (FBS)?

GENERAL CONSIDERATIONS

Family Based Service (FBS) is a specialised service in child welfare that focuses on the family as the target of intervention, rather than on the child or the parents separately. It uses the basic knowledge and skills developed in the field of family therapy to thoroughly assess and treat the family as a unit, usually in an intensive, time-limited period.

The philosophical underpinning and belief of the FBS programme is that the best way to provide services to a child is through strengthening and empowering the family as a unit. Removing the child from the family is traumatic for the child *and* the family, no matter what the circumstances of the abuse or neglect. Many studies indicate that children placed in alternative care do not fare better than those who remain with their parents over the long-term. Therefore it is believed that strengthening the existing parent-child bond and supporting the parents in doing a competent job is the best way to protect the children in the long run. Clinical experience often shows that even the badly abused and neglected child longs for his own parent and wants to go "home".

FBS is a sensible but drastic shift in the way we think about what is helpful for children and families. It requires specialised knowledge and skills to provide service to the family unit, the parent-child relationship, and other extended family and kinship relationships. FBS is designed to cooperate with the family by using the family's resources together with the formal and informal network of community resources.

By involving the family as a partner in the decision-making and goal-setting processes, and by recognising, respecting and using the family's existing strengths and resources, FBS strives to enhance the family's sense of competency and control over their own lives. The result is that families feel empowered and can become a safe and nurturing environment for the children, while maintaining the unique cultural and other characteristics of each family unit. With such help, families are able to live independently with a minimum of outside interference.

HOW IS FBS DIFFERENT FROM OTHER SERVICES TO FAMILIES?

For a long time the field of child welfare took an adversarial position with parents and frequently saw the children as the victims of bad or incompetent parenting. Often, the solution to a problem viewed this way was to separate the

children from their parents, thus putting them in the hands of alternative programmes such as "foster care". The intent was to force the parents to learn to be better parents. This period of separation was thought of as a time when the parents learned new and better parenting skills so that when they were reunited with their children, the family would function better. In reality, these ideals were not achieved.

Parents were given conditions under which they would be allowed to be reunited with their children, such as getting a job, cleaning up their homes, learning better parenting skills through attending classes, and engaging in counselling to solve the underlying problems that were thought to cause them to be abusive and neglectful of their children. They were expected to cooperate with social workers and follow their directions. Many parents did just that. Some reluctantly went along with these mandates and successfully reclaimed their children. However, most of these statutory clients were labelled "unmotivated" or "resistant to therapy". They were accused of "minimising" or refusing to "own up to" their problems.

Furthermore, such practices, based on simple "cause and effect" notions, viewed from an individually oriented perspective, had the effect of creating more hardship and trauma for the children. Not only did the intention of rescuing the children from their bad parents result in punishment for the children, it also became increasingly difficult to reunite the parents and children the longer they were separated.

Instead of encouraging cohesive and cooperative relationships as was intended, such practices had the effect of fragmenting the family and creating adversarial relationships among the family members. Communication became difficult among separate workers assigned to the child, the parent and the foster parents. When legal issues surfaced, there were cases that had three different attorneys representing three different views of what might be good for the family. I once worked with a family of five represented by five different attorneys: one for each parent because each had different goals, and one for each of the three children because all three were above the age of 12 and were entitled to individual legal representation.

In recent years, there has been an increasing awareness that the best way to help the children is to strengthen the family unit. Several factors led to this shift in thinking about the welfare of the children: a renewed recognition of the importance of the emotional bond between children and their parents, the fragmenting effect our child welfare policy has had on the family and the recognition that a lot of money had been spent with very few positive results (Peter Forsyth, 1988.) Workers' efforts to transform such "involuntary" parents into cooperative, hard-working, and motivated clients able to use individual treatment, support groups and parenting education classes, has had a limited success.

Lack of success with these statutory clients is often blamed on the hostile and angry personality of the client, her* lack of education and intelligence, and the impossible demands the system makes on the workers. All this is true. However, I contend that a more serious problem lies in the way we conceptualise the problem and thus arrive at solutions. The goal in child welfare must be to protect children through the strengthening of their families.

For too many years the goal of child welfare has been the "protection" of children. When the worker's goal is to "protect" a child, it implies that the child needs protection *from* someone, usually the parent. Thus, when a worker enters into a family system uninvited, takes on an investigative position on the side of the child against the parent and starts to tell them what they must do, it naturally becomes an adversarial and hostile relationship. To add insult to injury, the parent is often treated as if guilty until proven innocent. No wonder the worker feels frustrated, stressed, and burned-out, and that this results in extremely high staff turn-over, as high as 50% every six months in some agencies.

To return to the topic of the clients, these parents are often viewed as having defective and faulty notions of parenting, lacking problem solving skills, having no interest or ability in becoming good parents and being full of psychopathologies. Filling such a bottomless pit of deficits and solving "multi-problem" cases is an exhaustive and thankless task for the worker if this is how he conceptualises his job.

I believe that it is possible to "treat" statutory cases successfully when the worker sets his sights on client strengths rather than weaknesses, searches for exceptions to the problem, helps construct a different future through "miracle questions", and sets small and achievable goals. The premise of the Solution Focused Therapy model described here is that change is inevitable, and not a hard-won commodity. In the following chapters I will describe the role of the worker, the cornerstone of which is respect and admiration for the client's courage in struggling with the problems of living. This book will describe in detail how to establish a positive client-worker relationship, how to assess for change, how to ask questions that will generate solutions, and many other techniques of intervention.

* The client is referred to as "she" throughout since most clients tend to be single parent "mothers". The author recognises that many clients who are single parent "fathers" and the client is "the family unit". For identification, therefore, the worker is sometimes referred to as "he" although it is recognised that a large number of workers in this field are female. This in no way reflects sexual stereotyping.

HOW IS FBS COMMONLY PRACTICED?

FBS (also called Home Based Treatment, Family Preservation, In Home Treatment) has the following characteristics:

1. The ultimate purpose is to provide services to the family as a collective unit with the goal of preserving the family, while ensuring the safety of the family members.
2. The delivery of service is intense, immediate, and goal-oriented.
3. Service is provided by a treatment team (often made up of case manager, worker/therapist, and support staff such as the home-maker, child care worker). Following a period of need assessment, clear treatment goals are set, well-laid out implementation plans and a termination plan are formulated. The client participates in each phase from beginning to end.
4. Each worker carries a limited number of cases for a designated period of time (such as 90 days, 120 days, 6 months). Most treatment is offered at the client's home, although some programmes have facilities for office visits.
5. Some programmes combine a generic treatment service, with specialised services for cases involving sexual abuse, alcohol and drug abuse and domestic violence.
6. FBS is designed to respond to each individual family's unique needs. Therefore, the treatment approach is tailored to fit individual families.
7. Staffing is decided at intake and frequent case consultation occurs on an on-going basis.

ADVANTAGES

It is easy to see the advantages of the FBS programme to both clients and workers. Lower case loads mean more intense contact with the client family thus more information is available to the workers. More frequent observation of the family's functioning gives workers more opportunity to intervene in a timely fashion. With the positive changes clients show, worker enthusiasm is high, clients do better, and cases get closed sooner.

The majority of protective cases start out as involuntary clients or clients who are afraid of having their children taken away. They not only need reassurance that the worker is interested in keeping the family together, but also that the worker's job is to offer them services that will strengthen family functioning. Clearly it takes skill and time to influence clients to move beyond their initial reluctance and fear. FBS has had more successes in this respect than traditional child welfare practices.

Working with multi-problem families in any setting can easily overwhelm the worker who is then less effective than he or she could be. By identifying specific, concrete, measurable goals to work towards, and sometimes with time limitation, both the client and the worker can mobilise energy and resources, thus increasing the chances of success.

A team work approach supports the difficult decisions that workers must continually make. Much of the clinical aspect of child welfare work requires the worker to make judgements and to interpret data that is by its nature ambiguous. Having a team member who has another view or a different way of doing the same thing increases options as well as reassures the worker about safety issues. Having the opinion of another person on your side is simply more reassuring. The experience of many FBS teams across the country has shown that it reduces staff burn-out and improves staff morale and enthusiasm for the work. It is not difficult to understand that the energy and excitement the worker feels about what he does can easily become contagious and positively affect the client..

DISADVANTAGES

The disadvantages of FBS include the requirement that the worker must think differently about his role and conceptualise differently about the families he treats. Instead of being a broker who matches what the client needs with the resources in the community, the worker becomes the treatment person. Hence, it requires a new set of skills and new ways of doing things.

It requires the workers to respond immediately to the needs of the family, to show flexibility and the willingness to do things differently, and to be innovative and creative. It also requires workers to cooperate, become team members, and to take risks by exposing their work to colleagues.

Most of all, to be successful, FBS requires different organisational support and flexibility from management and supervisors who need to understand and support the FBS philosophy. Without system-wide support, backed by a willingness to reorganise the agency structure if necessary and on-going training, workers cannot carry out this difficult but rewarding task.

For the worker, it takes time and a shift in the way he approaches his work. He must recognise that the work he does right now may bring about a difference in the client's life some time in the future. Therefore the worker must learn to be patient about the client in a different way. Other community systems, such as the school, court, the medical system, and even other social service systems will require time to be educated about the unique and creative nature of FBS.

HOW HAS FBS BEEN INFLUENCED BY FAMILY THERAPY?

The basic concepts and philosophy of FBS are heavily influenced by Family Therapy. Family Therapy has developed over the past 40 years from a simple observation that an individual's behaviour happens within the context of an environment, that the environment influences this behaviour, and that, in turn, the environment is influenced by the individual's behaviour.

Interactionally, since B is part of A's context, what A does influences what B does and B's reaction influences what A does.

This simple observation changed the location of the "problem" from being something that an individual has, to something that is part of an interactional system. By changing the boundary around the concept of "problem", family therapy also changed the boundary around the parallel concept of solution. That is, the family became both the unit of observation and the unit of treatment.

Family therapy is based on the idea that the family can be seen as if it were a rule-governed system. For instance, an observer might notice that when A nags, he can predict with some certainty that B will withdraw. An observer might also note that when B withdraws, he can predict that A will nag. The observer might then say that A and B appear to follow this rule: if A nags, then B withdraws, and when B withdraws, A nags. Which comes first, nagging or withdrawing, depends on when the observer starts describing what he observes. With the enlarged boundary, the problem is not simply that "A is a nag" or "B is withdrawn". Rather the problem can be seen as involving the interaction between nagging and withdrawing.

Family therapy is based on the idea that human systems are fluid, evolving and changing, and that within this particular context there is no clear connection between "cause and effect". For instance, there is no way for either participants or observers to know whether A's nagging caused B to withdraw or B's withdrawing caused A to nag.

Family therapists tend to believe that when there is a shift in the nature of interaction among family members, this will make it possible for the individual member to change; and when the individual member changes the rest of the family will be affected in turn. The context or environment must also change to accommodate the individual's original change. That is, if A stops nagging, then B will change by either stopping withdrawing or withdrawing more. If B stops withdrawing, then A will change by either stopping nagging or nagging more. Either way, there will be some sort of change.

However, as we all know, stopping undesirable behaviour is not easy. A will find it far easier to substitute a different behaviour for the nagging than to simply stop nagging, and B will find it easier to do something different rather than to stop withdrawing. Although A and B might not be able to see it, an observer will be likely to notice that there are times when A and B interact without either nagging or withdrawing, and these non-nagging, non-withdrawing behaviours could be used to change the nag-withdraw pattern. For instance, any one of A's typical non-nagging behaviours toward B might be substituted for the nagging when B withdraws, and then B will be likely to respond without further withdrawing.

The interrelationship between an individual and an environment led family therapy to the idea that a small change by A can be followed by disproportionately larger changes in A's family. For example, if A starts being nice to B and B responds positively, then this shift can create a chain reaction within their context. The more often A and B repeat this positive exchange, the more likely it is that this will influence C and D. This is called a "ripple effect".

With an enlarged boundary around solutions, family therapy points to the idea that developing solutions within the interactional context depends on at least one of the involved individuals doing something different from their predictable behaviours.

As you can easily see this is a radical departure from the traditional assumptions about individual mental health problems and treatment. In this traditional view the individual must get well before behaviours change, whereas in the interactional view the individual's behaviours may change as a response to changes taking place outside that person. It is easy to see that, compared to traditional individual psychology, this interactional view tends to be more optimistic about the potential for change.

This way of looking at the child and his social relationships has a significant impact on the way we provide child welfare services: instead of looking at the individual child or the parent as the focus of change, the individual child and the parents are looked upon as a resource for change.

The clinical practice of Family Therapy is significantly different from an individually oriented treatment model. Even when an individual client is treated, the therapist looks at her problems within the family context and looks at how she is influenced by and affects the rest of the family. Therefore, the treatment focus is on the family interaction patterns and not on the individual psyche.

SOLUTION FOCUSED THERAPY

Solution Focused Therapy, a model of intervention developed and described by de Shazer (1985, 1988, 1991), Insoo Kim Berg (1988, 1990), and their colleagues at Brief Family Therapy Center in Milwaukee, is a new treatment model that is considerably different from others.

It is based on some of the same interactional, individual-in-the-context-of-the-environment ideas as family therapy. From that same philosophical base, it departs significantly in a number of different ways. The most important difference is the view of change. Unlike the accepted view of family therapy that the family unit operates on a principle of pressure to maintain a homeostatic balance and maintain its boundary, Solution Focused Therapy views change processes as inevitable and constantly occurring. Like the

Buddhist view that stability is nothing but an illusion based on a memory of an instant, it views human life as a continuously changing process.

Taking this basic view, Solution Focused Therapy pays close attention to the exception to the problem, that is when there is a small change to the stability of the problem state, and sees such exceptions as a key to finding solutions. It is easier to enlarge on the existing change, however small, than to create something that does not exist.

FOCUS ON SOLUTIONS, NOT ON PROBLEMS

Solution Focused Brief Therapists believe that it is easier and more profitable to construct solutions than to dissolve problems. Their clinical experience is that activities that centre around finding solutions are distinctly different from problem solving activities. It is simpler for the client to repeat already successful behaviour patterns than it is to try to stop or change existing symptomatic or problematic behaviour. For example the activities a worker may engage in to "protect a child" from his abusive or neglectful parent are quite different to those which the same worker would engage in when focusing on "building safety" for the same child. What the worker will do becomes even more different when he looks for, and finds, periods when the parent is already successful in ensuring the safety of the child. This is clearly an easier and simpler type of solution.

Clinical activities that help to enlarge and enhance those behaviours around exceptions to the problem provide the keys to finding solutions. The following are important ways to look for exceptions.

PRE-SESSION CHANGE

Frequently, clinicians encounter clients who report that since they have been contacted by the child welfare department to set up an appointment for a home visit, things have changed markedly and in the direction they wanted their life to go. When the staff of Brief Family Therapy Center paid close attention to this phenomenon (Wiener-Davis, Gingerich, de Shazer, 1988), they found that about two-thirds of their outpatient clients report some form of positive change in the area in which they were seeking help through therapy. Understanding and paying attention to such pre-session change leads to quick solution finding since the initiative for positive change has already started to work and the family already knows what they need to do in order to bring about even a small change.

Unless they are asked, most clients often do not think the change is significant enough to report because it appears such a small change compared to the massive problems they are faced with. Most workers either ignore reported pre-contact change, or they brush it aside as a defensive manoeuvre, minimising the seriousness of the problem.

Since the client has already made positive, goal-related changes, the worker's task is to amplify, reinforce and help the client to repeat the positive changes they have already made on their own. Later chapters will describe the techniques for implementing this approach.

WHAT ARE EXCEPTIONS?

Exceptions are those periods when the expected problem does not occur, for example when a child who "fights all the time" or "lies all the time" has a period when he is "cooperative" or "honest". When a great deal of attention is paid to the interactional patterns around those periods, that is to what mother does, how the child starts to be cooperative or honest, to what else goes on when he "behaves", clues may be found as to what the client needs to do more of. To most clients, at first, exceptions to the problem seem unimportant or insignificant. However, when both mother and son can find ways to repeat the behaviours that surround exceptions, the problematic situation becomes less overwhelming, more manageable, and eventually disappears.

Change occurs in many different ways: emotional, perceptual, and behavioural. When feelings towards a problematic situation change, it is possible to make a perceptual shift, followed by different behaviour; when a problematic situation is perceived as positive, one can make behavioural changes and think and feel differently about the same problem thus creating different emotional reactions; when one behaves differently, emotional and perceptual changes follow. These are as interconnected and interrelated as A's nagging behaviours are related to B's withdrawing behaviour, making it difficult to figure out which came first, the familiar "chicken or egg" dilemma. Instead of trying to figure out whether it was the feelings, the thoughts or the behaviours that came first, paying close attention to how the client made the shifts is much more profitable. Repeating these small but successful behaviours forms the basis for solutions. They become the keys and clues for solution. Details on how to tackle such trigger points are described below.

DELIBERATE AND RANDOM EXCEPTIONS

In our study of exceptions, we found that there are two types of exceptions that clients describe: deliberate and random.

A deliberate exception is one which the client is able to describe creating in a step-by-step fashion. An example of such an exception is: "I forced myself to get out of bed, forced myself to go downstairs, made coffee, got the kids off to school, and forced myself to get out of the house. It helped me to feel a little bit better about myself." Since the client can describe what she did, she can repeat those behaviours that helped her to feel better. Clearly the task for the client is to "do more of it".

Where random exceptions occur, either the client is unable to describe her successes or she attributes them to someone or something as if she had no control over the episode. For example, the client will describe the day she felt a little less depressed as "I have no idea what made the difference on Wednesday. I just woke up feeling better", or "It was the day a package arrived from my grandmother who raised me", or "When I woke up the sun was shining and I felt better". Since the client sees herself as having had no part in creating the exception, it is difficult for the client to replicate. Such situations call for a different intervention or task, one of predicting what kind of day she will have the next day. A review the next day of what she did to have "a good day" and how this is different from what happens on "bad days" will provide directions on what to "do more of". More about this will follow later.

GOAL-SETTING

FBS cases, more than any others, require clear goal-setting if the worker is to avoid the dangers of interminable contact, possibly only terminated by emergency intervention to protect the children.

There are two different ways to negotiate goals. One is through setting a defined number of sessions, 5, 10, or 20, or by determining a period of time over which to meet, 30 days, 3 months, 6 months, or a year, marking the end of the contact through a lapse of time. Such an approach has positive and negative aspects. The positive aspect is that both parties will know clearly when the end of the contact will occur and work towards that date. The negative aspect is that both parties can just "buy time" waiting for the end to come, with no clear sense of what has been accomplished.

The second approach is the one I advocate: having clear, well-formed goals that can be described in a specific manner, and are concrete enough so that they become outward indications of the internal changes that are occurring.

The "Miracle question", a goal-setting and solution-finding technique, helps the client specify how things will be different once the problem is solved (see Chapter 6). Clients are asked the following question: "Suppose there is a miracle tonight while you are sleeping and the problem that brought you to the attention of child welfare is solved. Since you are sleeping, you do not know that a miracle has happened. What do you suppose you will notice that's different the next morning that will let you know that there has been a miracle overnight?" This "miracle picture" is used as a roadmap for figuring out where the client wants to get to and for suggesting what needs to be done to accomplish the desired changes.

The model described here is often characterised as "goal driven", that is the therapeutic activities that both client and therapist engage in are always related to goals. Unlike the medical model, where the professional becomes an expert whose role lies in diagnosis, setting goals for the client and laying

out the plans for the client to implement, Solution Focused Therapy follows the client's goals. For instance when the client says to the worker her goal is to "get the social service out of my life", the worker agrees with the client that it is a worthy goal to work towards, since the ultimate goal of the worker is to successfully terminate the contact with the client. When the goals are laid out by the client, not defined and imposed by the worker, the client is more likely to be committed to achieving them.

Guidelines for setting "workable" goals for FBS will be described in chapter 5.

THERAPIST ROLE

It is already clear that Solution Focused Therapy calls for drastically different activities on the part of the worker. The worker-client relationship is conceptualised as the product of the interaction between the worker and the client, thus forming a unique but temporary system engaged in finding solutions to the client's problem. When the task is accomplished, the relationship ends.

The worker is actively involved with the client in looking for pre-session change, exceptions to the problem, constructing imagined solutions, asking questions that will help the client to discover her own solutions. By asking what appears to be a simple question the worker is intervening in the system. Since the solution is generated from within the system it is more likely to be congruent because it is a natural part of the family system. Since the solutions are generated by the client, and not introduced into the system from outside, the changes occur rapidly and the likelihood of setback is greatly reduced. Our study indicates that as time goes on, the "ripple effect" appears to create long-term positive influence. (Kaiser, 1988).

THREE RULES

1. If it ain't broke, don't fix it.

Simple observation will reveal that A and B are not always nagging-withdrawing-nagging. Even the most chronic of troublesome patterns is absent now and then. Sometimes, in fact, the problematic pattern is only a very small part of the client's life. Except in rare circumstances, even abusive parents do not abuse their children all the time. There are frequent periods, which sometimes last for a long stretch of time, when that same parent can be loving, quite nurturing, and behave in a very competent manner.

The concept of determining what is "not broke", and therefore does not need fixing, is a subjective one at best and not a scientific one. Workers need to have a very broad view of what "works" and "does not work", since much of what causes the client to come in contact with the child welfare services stems from extreme differences in culture and life-style.

Two
THE INITIAL STAGE

WHAT ASSESSMENT IS DESIGNED TO DO

The most frequent misuse of what is commonly called "assessment" is when it becomes a listing of all the things that are wrong with the client. You will often see a detailed account of what a poor childhood a client had, how the client was abused, grew up in a foster home, has no contact with her mother, how she was "hooked up" with shady characters who used her, how each of her four children has a different father, and how she neglects and abuses her children now.

Such a list implies that the client is doomed to fail in life and, thus, even before the first visit, it is easy for the worker to take a negative view of the client. Such a view clearly will not help the client, especially since we all convey what we think and feel in subtle, non-verbal ways. Once we start to feel overwhelmed by the problems, we tend to look for ways to justify our failure, and so we describe clients as "unworkable", "unmotivated", "lacking insight", "resistant" or "not ready for therapy".

What is most important to remember is that the client may not agree with the laundry list of problems at all but may instead have her own ideas about what the problem is. If this is the situation, we have a clash over what the problem is and therefore over what to do about it. It is not hard to imagine how such clashes can lead to "client resistance", "avoidance", "passive-aggressive behaviours", or "non-compliance" from clients.

A way of avoiding such "resistant" or "uncooperative" client behaviours is to conduct an "assessment" in such a way that a list is made of activities that both worker and client need to do. Making a master plan to chip away the problems, aiming for small changes and making a list of activities that will move you towards the "easiest" way of finding solutions, will be a much more helpful way to "assess".

As you move along through this book, you need to bear in mind that the "assessment" is not best thought of as a list of "what's wrong with this client", but as a map which you and your client contract together in order to figure out where you both want to get to. Since you will be the guide, perhaps you will need the map more than the client does.

A. PRE-ASSESSMENT INFORMATION

Before meeting with the client for the first time, gather all the data you have about the new case. It may be information from medical sources, court, school systems, relatives, church, neighbours, or from a previous contact with a