



Week 8 - **Solution Focus Interventions**

Solution Focus Simulated Interview (Chat Exercise) Brief Therapy and Solution Focus Interviews Simulation

Asking for Solutions: Exceptions, Competencies, and Strengths

Clients' Workable Solutions; Homeworks; Families as Resources

This is going to be a different kind of event. We will have a simulated interview with all of you playing different roles. Half of you in each group will play clients and the other half will be interviewers. To make things easier, you are being assigned this role alphabetically. The first half of the group participants will be a family (or couple) and the second half will be an interviewer. You will participate in the chat room in the roles that you have been assigned. For clients, they will create a family that will be interviewed by one interviewer at a time, the family will interact as they see fit (If needed, please provide non verbal clues using words written in the chat or the whiteboard and using parenthesis). As the interview develops, I will ask another person to replace the interviewer so that every one of the interviewers has a chance to carry out an interview. Whenever I give instructions related to how to play, I will do so using words in parenthesis, for example: (Susan is your turn to start interviewing). The rest of the interviewers will stay quiet and take notes at home and plan for what questions they will ask. If you come late, please stay quiet until I have assigned you a role to play. We will carry out the simulation for about 30 minutes and leave 15 minutes to debrief. The required readings and the links in the session point out to resources to be able to ask questions using a brief solution strength oriented perspective. BE PREPARED!!

The Basics (Berg & Reuss, 1998)

“The field of substance abuse is the only professional health care discipline that does not trust an optimistic and positive client’s self-report.”

Recovery starts when the client has made a decision (or have thoughts about it) to start the process: Recovery begins on the first day a person has the thought for the very first time, “I’ve got to do something about this drinking”

Berg & Reuss call the first steps “pretreatment change” and to capitalize on this, they recommend the therapist give a homework assignment between the first phone call and first office visit. For instance, they may advise a person to fill out a competency worksheet.



There are two common client-therapist relationships: the customer-type and the visitor-type: Knowing the type of relationship we have with our clients helps us modulate the pace of our first session. In a customer-type situation, clients are ready to do something different to make their life or the life of a loved one better.

The therapeutic relationship: A positive working relationship helps the “medicine go down” but does not produce change. Doing something different is the way to change.

Negotiation of termination criteria must begin before treatment can proceed and it must continue throughout the contact.

When we have a customer-type relationship, we think that whatever the client wants is a good place to start therapy. In responding to: What do you want to get out of therapy? When the client tells us he wants something, we are encouraged.

When we have a visitor situation with our clients we must take a very different approach. We start with what the client is willing to work for. He just sits there and says, “Your guess is as good as mine”. Our next question is, “So what do you think it will take so-and-so to leave you alone?” When the therapist begins to argue in favor of change the client can only argue against it.

Berg and Reuss do not use terms that pathologize clients (i.e., dysfunctional): They oppose the use of such terms and the thinking that goes into labeling them as such. When professionals use these labels, it is difficult for the client to remember that these labels are just someone’s idea about reality.

NOTES ABOUT EXCEPTIONS TO PROBLEMS

All substance abuse problems have exceptions: Those the client creates by something he purposefully does and those that just seem to happen when the problem does not seem to be so much of a problem. It is the therapist's job to mine that exception for details asking questions that point our client in the direction of a workable solution:

When exceptions are not of our client's own, we use the miracle question to continue to develop our client's ideas.

We use the word "suppose"

We do not refer specifically to any problem.

After we finish asking a question, we pause for a very long time.

We say, "guess"

We facilitate visualizations

Ask – "what will you be doing instead when you are not ...?"

"How will you know you are feeling (rested)?"

Simply ask "What else?"

"What will he notice is different about you?"

It is best to acknowledge this desire for a miracle. "And on this miracle day when you noticed you were no longer HIV positive, what would you be doing? Could doing that help now?"

"How will that be helpful?"

The use of exception questions

"When was the most recent time when small pieces of this miracle were already happening?"

"What would you have to do more of to make even a small part of this miracle day come true?"



“What would have to happen more often for this miracle to take place?”

“When your husband stops drinking, what will he notice you doing differently? What will you have done, to do that?”

Try to limit the discussion to one miracle

Distinction between compliance and change

“How can your partner tell that you have learned your lesson and that you will never do it again?”

Scaling Questions:

Use numbers to replace the word description

A scaling question asks the client to evaluate either a problem or a solution on a scale of 1 to 10.

It is useful when there is a disagreement between people.

“How long do you need to stay here before you are ready to move to the next step?”

Scales can be used for assessment of client’s progress in therapy.

“What did you find helpful about AA? How have you been putting this to use in your daily life?”

Managed care companies accept scales.

The Nightmare Questions

Only after our attempts to build a solution using questions about the pre-session change, exceptions, and miracle days do we give ourselves the permission to ask the “nightmare” question.

Alcoholics see abstinence, not as a solution, but another “damn problem”.

“What would you notice tomorrow morning that would let you know you were living a nightmare life?”



By using these, we are using problem talk to build a solution our client can live with.

“Are there times now, when small pieces of the nightmare are happening?”

“What would it take to prevent this nightmare from happening?”

“When she is living her nightmare, and you are living yours, what will you notice about each other?”

It is unethical waiting for the client to hit bottom. Helping him/her imagine ‘hitting bottom’ is safer.

“Denial” usually means the therapist and the client are in disagreement about the construction of the problem, or the best method to reach a solution.

Denial is in the theory of the therapist.

Coping Questions

“How have you managed to come this far without killing yourself with your booze?”

Not getting any worse takes a significant amount of effort.

Useful coping questions to ask about the seriousness of the problem.

These descriptions were never meant as an explanation or a prescription.

One day at a time.

CLIENT'S WORKABLE SOLUTION:

(Berg & Reuss)

The only solution that will work for a client is the one they create.

It is helpful to see family members as resources in building solutions.

There are many important things that problem drinkers do, that had nothing to do with the drinking.

Look at the bigger picture.

The decision of what is best for the client is made jointly: Hold off on making these good suggestions until after you have asked the client for her good ideas about making changes: It is easy to burnt out when you stop building solutions with your clients

Goals are what clients bring to the session; solutions are what we create cooperatively with our clients.

Guidelines for a well-formed solution.

Better long-term results with abstinence but there are studies that challenge an abstinence-only approach. In the battle between abstinence and moderate drinking there is no best strategy. Client preference is still the best predictor.

“ During the interview I noticed your curiosity about how alcohol has affected you and I’m wondering if you would like more information from some of my resources.

A menu approach: Foster the broadest and most flexible range of treatment programs possible: Flexible and broad enough that it can be customized to take advantage of client’s resources. This menu of services is cyclic rather than linear.

HOMEWORKS: (Berg & Reuss)

Homework is the treatment plan in action in the client’s real-life environment.

To do more of what is already working.

When the homework has been a failure we simply apologize for leading the person astray. “ When that failed, what did you do that worked better?”

Change determined by a coin flip: Heads means they do the activity they described earlier.

Visitor type relationship – compliment success in therapeutic behavior

Customer type relationship – compliment the client on hanging in there.

Homework is our way of extending therapy to the client’s natural living environment so that she can practice, experiment, and modify solutions to fit her natural way of living.

Agree with the client



Agree with client- goals
Use the client's language
Emphasize that this is a good time to come for therapy
Direct and indirect compliments
Help client feel successful
Simple, easy, doable homework tasks.

AFTER THE FIRST SESSION:

Never know how a session went until the follow up session
If we don't know how the client is making therapy work, we can't do more of it.

We do not believe that the client came to therapy to hear the therapist's life story

How is information about the therapist's life going to be helpful.

When this is an important part of therapy, we refer the client to AA or a support group.

EARS – elicit, amplify, reinforce and start again.

ELICIT:

Ask about positive change

“What have you been doing to make life better?”

“What would _____ say is better?”

“What have you learned?”

“You must have very good reasons for drinking. What are those reasons?”

AMPLIFY

Ask for details about positive change

“Who noticed?”

“When did this happen?”



“What was going on there that helped?”

“How did you do that?”

REINFORCE

Make sure client notices and values positive change

START AGAIN:

Go back to the beginning and focus on client-generated change

ENDING THERAPY

The client-therapist relationship encourages change, but does not cause it.

Many studies indicate that six is the average number of sessions that any therapist can expect in an outpatient setting.

RELAPSE

Relapse is a normal learning experience. It means there was success.

“ How did you know it was time to stop drinking again?”

“ Who besides yourself was instrumental?”

Find the details of how client stayed sober before the relapse.

How is the client sober now?

What is different about this relapse and staying sober, compared with previous ones?

More Useful Questions

What is the goal of treatment?

What are the benchmarks that will let you know you are moving in the right direction?

What previous experiences do you have that will help?

What needs to be different when you return?



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