Utilizing Solutions - Focused Brief Practice as Assessment for Intervention
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INTRODUCTION

Solution-Focused Brief Therapy (SFBT) was developed by Steve DeShazer, Insoo Kim Berg and their colleagues in the 70's and 80's. SFBT is a practice-based model of helping people, families and children finding solutions or methods that can help them achieve a more satisfactory future. The process is not a problem-solving strategy because it is about co-constructing goals, exploring exceptions (those times when clients', families', and children's' lives are going the way they want them to go)—identifying strengths and resources, while maintaining a future orientation, i.e., "What will you be doing when you don't need to come here anymore? Or "What will your children be doing when you don't have as many concerns about them?" DeShazer and Berg's work suggest a number of underlying principles:

1. Emphasis on mental health, not pathology: In all SFBT sessions, client, family, or children successes, strengths, resources and abilities are emphasized vs. their limitations and deficits (Berg and Miller, 1992). Clinicians utilizing this view are more interested in discovering what works and what is right, rather than exploring what is wrong and trying to fix it. They become very curious about how strengths can be built upon.

2. Utilization: This is a method of accepting the family frame of reference. Their existing resources, skills, motivation, behavior, symptoms, social network, circumstances and personal idiosyncrasies are used to lead them to their desired outcomes (O'Hanlon and Wilk, 1987).

3. An atheoretical/nonnormative/client-determined view: Few assumptions are made about the "true" nature of the child or family problems. The family is viewed as the expert about their solutions, and the clinician is more of an apprentice whose job is to learn about the unique ways the family has conceptualized their complaint(s) that brought them into the clinic (Berg & Miller, 1992).

4. Parsimony: Solution-Focused therapists prefer the simplest and most straightforward means to a desired outcome. DeShazer often quotes the 14th Century philosopher, William of Ockam, "What can be done in fewer means is done in vain with many (DeShazer, 1985 in Berg & Miller, 1992). So, the clinician wants to keep things simple without introducing complex theories or explanations about problems and their resolution. For example, solution-focused advocates would never say that symptoms are "just the tip of the iceberg", preferring to view symptoms as things that come and go. Such an approach is more interested in the times that symptoms go, or aren't present, and what is different about those times. This positive orientation does much to reframe the family's view of the "problem".

5. Change is not only possible but inevitable: SFBT clinicians believe they have yet to come upon a problem that is absolute, or in other words, a problem that happens all the time. They believe that change for the better has no lesser odds of happening than change for the worse. So, they are constantly looking for these changes toward the better

and want to highlight them to the client, family, or child as perhaps a "difference that makes a difference."

6. Present and future orientation: SFBT is not particularly interested in exploring the past, with the exception of reviewing past successes. Their focus is on what is working now and what needs to happen for a satisfactory future adjustment. This process fits very well into family resiliency goals.

7. Working what works: The approach suggests that if something isn't broken, don't fix it. It also suggests that when a family knows what works they should do more of it. Finally, the approach endorses the idea that, if something isn't working, do something different.

PROCESS

With these as guiding principles, the clinician facilitates conversations around five kinds of questions: goal, scaling, miracle, coping, and exception/instead questions. Each type involves inquiry about individual or family goals and identifying successive steps for those goals.

1. Goal questions: All sessions are begun with the following types of questions: "What has to happen here today for you to later think that coming in was worth it?" These questions help people decide what they want to work on——the clinical staff not presupposing the family's goals. Some examples follow:

'How can we be most helpful to you?"
"What would you like to accomplish as a result of coming here, so that one day you can look back and say, 'That wasn't a terrible waste of time'?"
"How will you know that coming here was helpful for your child or family?"
"When all is said and done, what will tell you it wasn't a waste of time?"

2. Scaling questions: It is the view of SFBT clinicians that language and conversation are the only true "tools" of therapy, but this is a potential problem inasmuch as language can be very vague and uncertain. Numerical language is useful in helping clients, parents, and even small children clarify vague ideas and goals by the use of scaled symbols such as degrees of smiley faces. Basic Scaling question may be like the following:

On a scale of 1 to 10, where 1 is, "perhaps the worst things have been for you" and 10 is "considering where you would like your life to be, where do you see yourself today?"

Note: Many clinicians misunderstand scaling questions as an assessment question, as if the scale of 1 to 10 is based on normative standards and the answer "4" has some analytical meaning.

To this end, scaling questions have little value. In this model the questions are used to facilitate movement, identify successive steps (goals), measure perception, motivate and to encourage.

Sample Follow up:

"You see yourselves or your family at a 4. O.K., this is good. What will be different as you begin to see yourself or your family at a 5?"
"As you leave here today, what small things will your family be doing differently when you are at the next step on the scale?"

3. Miracle questions: A clinician may ask the parents and adolescent the following question to help them identify their goals:

"I have a strange question for you, one that you have probably never thought about. Suppose you leave here today, go about your business, and get ready for bed. And let's suppose that when you go to bed and fall asleep, that a miracle occurs. And let's say that this miracle occurs in such a fashion that these problems that you are coming in with today are solved. O.K., now here is the tricky part. Since the miracle happens while you are sleeping, there is no way for you to know that the miracle did indeed happen."

"What, then, do you suppose will be the first small signs you will notice in the morning that will tell you a miracle occurred?"
(to the child) "What will your parents/siblings notice/ or do?" -
(to the parent) "What will your children notice or do?"
(to the spouse) "What will your spouse notice or do?"
(to the child or parent)"What will your friends notice or do?"
(to the adolescent or parent) "What will your employer notice or do?"

4. Exceptions and Instead questions: SFBT practitioners feel that they have yet to come upon a problem that is "absolute." In other words, one that is evident all of the time, 24-hours-a-day and seven days a week. While the relevance of the problem may be rather significant to the individual or family, the "times" of the problems are often in the minority (but unfortunately, less relevant to those individuals involved). So, we continue to look for "exceptions", that is, those times that the problem does not occur. Practitioners have noted that it is often too easy to identify instances of things that don't work because they stand out, are irritating, frightening, make one feel helpless, etc. Things that work tend to be less obvious and thus need greater focus.

Exception questions:

"Tell us about the times when your family members were considerate to each other. What were you all doing when this occurred? What was different about these times?"
"When confrontation is less of a problem, what will you be doing instead?"

Instead questions:

People experiencing difficulties often talk about "not doing" one thing or another. The problem with "not doing" something is that it leaves a void. It is much easier for people to find a viable replacement behavior. People don't behave in a vacuum, they typically have very good reasons for their actions and quite often it is to meet basic needs. It is important to find alternatives to the unsuccessful strategies in helping to meet those needs:

"When your child is not depressed, what will they be doing instead?"
"When you stop fighting with your husband, what will you/he be doing instead?"

***Coping questions*:** Many times clients and families come to us and are in very dire straits, discouraged, helpless, hopeless and feeling that their lives can't improve. They have often been dealing with very difficult circumstances within a multiplicity of problems (serious poverty, homelessness, criminal activity, substance abuse, physical and emotional barriers, etc.) and we are sincerely interested in why things aren't even *worse* what are they doing? So, we ask, for example:

"O.K., you're at a 1 – what are you doing to keep things from getting to a zero?"

"What have you done to cope with these very difficult circumstances?"

"Can things get worse? What are you doing to keep things from worsening?"

We use coping questions to highlight strengths, resources and what families are doing that is helpful. These inquiries can provide much needed hope by identifying the things that they *are* doing right? Often, clients will tell us that it is good to hear that, "At least I'm doing something right." Remember that these families usually have a long history of hearing about all the things they do wrong. So, this kind of feedback can be encouraging while instilling a sense of hope.

This brief overview should have been helpful in increasing your understanding about the nature of our work. We believe in looking for resilience, strengths, resources and protective factors, such as those times when the family or child problem(s) either wasn't present or was less of a problem, and when positive family goals are focused upon, instead of compulsively placing emphasis on problems.