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RADICAL ACCEPTANCE

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Each seminar, every training, and all conferences I do each year brings to my attention again how frequently people get the mistaken idea that "simple means easy." In each and every seminar and training I do, whether in the U. S., Europe, or Asia, people remark about how simple Solution-Focused Brief Therapy (SFBT) is -- or appears to be -- until one tries to use the approach. At this point one discovers just exactly how difficult it is to use and soon discovers that keeping things simple involves a lot of self-discipline. There are two topics that in particular that appear "simple" but turn out not to be "easy"; using the miracle question and scaling questions.

The miracle question (de Shazer, 1985) has been a routine part of the practice of Solution-Focused Brief Therapy since 1983. Over the years Solution-Focused therapists have found it useful for helping clients describe what it is they want from therapy. It is usually asked in the first session to help both therapist and client figure out how the therapy can be useful to the client. However, making the miracle question work for the therapist and client is not always easy. The therapist cannot read it off of a 3x5 card and expect that the client will be able to respond in a useful way. I would like to tell you about what I have learned about asking the miracle question and to offer some suggestions which I hope you will find useful.

Usually, I introduce the miracle question by telling the client that I have an unusual and perhaps difficult question to ask, one that takes some imagination. I then pause, waiting for some signal to go ahead. Then I begin to ask in this way:

"Suppose . . . [A pause always follows this word. "Suppose" is a nice, harmless, but useful little word. The pause allows clients to wonder what strange and difficult thing I might ask them to suppose.]

after we finish here, you go home tonight, watch TV, do your usual chores, etc., and then go to bed and to sleep . . . [A pause here. So far, what I am asking the client to suppose is very normal, everyday stuff. Not so strange after all.]

and, while you are sleeping, a miracle happens . . . [Pause. The context for this miracle is the client's normal, everyday life. Thus it is a "normal miracle" and not something too out of the ordinary. However, this construction does allow for any kind of fantastic wishing on the client's part. But this pause should not be too long since -- if it is too long -- the client is likely to interrupt and say that he or she does not believe in miracles. If the client should say that he or she does not belief in miracles, it is frequently enough to say something like this: Me neither (which is true), but pretend -- for the moment -- that you do."]

and, the problem that brought you here is solved, just like that! . . . [Pause. Now the focus is on one particular miracle that is in line with his or her coming to see a therapist. Failure to include this focal point will often lead to the client giving a response that is vague, general, and so nonspecific as to be almost useless.]

but, this happens while you are sleeping, so you cannot know that it has happened . . . [Pause. This is designed to allow the client to construct his or her miracle without any consideration of the

problem and without any consideration of the steps that might be or might have been involved.]

once you wake up in the morning, how will you go about discovering that this miracle has happened to you?" . . . [Pause. This is the point when the client has his or her most difficult work to do. Therefore, the therapist should be prepared for what seems like a long silence. The therapist should not interrupt this silence; it is the client's turn to talk, to answer the question.]

With some frequency, this client's initial response will be: "I don't know." This is a reasonable thing to say. We have found that the most useful thing a therapist can do at this point is to simply continue to be silent and wait. (All conversations involve taking turns talking and therapy is not an exception. If the therapist does not take a turn here, then it is still the client's turn.) Usually the client will then begin to describe the morning after the miracle in relatively concrete and specific terms.

Years ago we hesitated to ask the miracle question in some situations, but -- through experience -- I have learned not to anticipate the client's response and, furthermore, I have learned not to modify the question at all in anticipation of how the client is going to respond. For example, some years ago a client came to see me who had lost his left arm in an industrial accident. I hesitated and postponed asking the miracle question for as long as I could. I was afraid that he would say, as I am sure I would in that same situation, that the miracle must restore his lost left arm. Finally, after my teammates called in suggesting I ask the miracle question, I asked him and he gave the predicted answer. I did not know what to say or do, so I just nodded and sat there. After a brief interval, he said: "Ah, but you mean something that can happen." He went on to describe how his wife would greet him with a smile in the morning, how he would return that smile, how surprised she would be, etc.

This sort of response helped me to learn that the miracle question could usefully be asked even when, or in fact particularly when, I anticipate a not so useful response. The miracle question is designed to help clients clearly describe what they want and wanting his left arm back is perfectly reasonable, although impossible. In somewhat similar situations over the years I have found that the greatest majority of clients do not give unreasonable responses and, in fact, I think their miracles are often far smaller than mine would be were I in their situation.

Scaling questions have been part of my practice since I learned about clients' spontaneous use of such ratings in the early 1970s. At first I used scales to attempt to get some sort of way to describe vague things that are very difficult to describe such as "(degrees of) depression," "(degrees of) anxiety," "(degrees of) satisfaction," and "(degrees of) effective communication between people," helping the client to access their situation and to shift from general black & white constructions, i.e., either depressed or not depressed, to something more discrete and descriptive, i.e., sometimes more or less depressed. Over the years my use of scales has increased in both frequency and importance. Now clients will frequently report -- when asked -- that they found the scales to be the most useful and important part of the therapy because these scales give them a way to assess their own situation and to measure their own progress. Now I will inevitably use at least one scale in every first session and most subsequent ones, a scale that can loosely be called "the progress scale." It goes like this:

"On a scale from "0" to "10," with "10" standing for how things are the day after the miracle and "0" standing for how things were at the point you called and arranged for this appointment, where would you say things are right at this moment?"

Obviously, this question is asked after we have explored the clients' response to the miracle question as fully as possible. Most clients will say that things are currently at "3" (in the first session) which of course means that things have already gotten better. We will then explore

together, in as much detail as possible, the differences between "three" and "zero." In the second session and later ones, the question goes like this:

"Remember the scale, with "10" standing for the day after the miracle? Where would you say things are today?"

My experience suggests very strongly that the therapist should not remind the client about previous ratings. If, for instance, the therapist says "Last time you were at three," I found that there is a very strong tendency for the client to again say "three." If, however, the therapist does not remind the client, then there is a very strong tendency for the client to say "5" in the second session, and "7" in third and later sessions. Once the client has given a rating, then the therapist can explore the differences between "three and five," "five and zero," etc.

I have learned to accept whatever the client answers as a good and informative answer. At one time I used to prefer higher numbers, thinking that the higher the number the better. However, one day I was behind the mirror watching a second session when, after hearing about how much things had improved for almost twenty minutes, the client said she was at "three." The trainees and I were disappointed, saying to ourselves "Only 3!" The therapist in the room, however, did not say anything and then the client continued with "That's pretty damn good, isn't it?" It turned out, she thought "4" was as high as it was possible for her to go and thus she was almost there. (On a scale from "0 to 4," "three" represents rather significant progress!) If the therapist had expressed disappointment, then the client's wonderful progress would probably have been undermined. As a result of such experiences, I am likely to shake the client's hand no matter what the number the client gives, even if things have gone from "+3" to "-1" since even minus one is better than "-2" and, naturally, the question follows: "Minus one. Hmmm. How come, do you suppose, it's not "-2?"

Such radical acceptance is difficult for many people. It requires a lot of self-discipline and a good deal of close-listening. It is not easy to give up making judgments about how high the number should be or how unreasonable and unrealistic the initial response to the miracle might be. Long experience with many clients and many, many hours of disciplined observation suggest that radical acceptance is a useful stance for the therapist to take. It turns out that clients are more reasonable than we expect and they can be counted on to modify their views once we have accepted them. Such modification is, however, unlikely if the therapist points out the unrealistic nature of the client's picture of the miracle or suggests that their rating is somehow "wrong." The client's answer needs to be accepted fully and literally -- this is where the art of the approach comes into things.

REFERENCES

de Shazer, S. (1985) Keys to Solution in Brief Therapy. New York: W. W. Norton.

BEGINNINGS

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IF YOU HAVE FURTHER QUESTIONS ABOUT THE BEGINNINGS AND DEVELOPMENT OF BFTC Email ME AT: briefftc@aol.com UNDER THE TITLE "PART 2". I WILL (at least) TRY TO ANSWER THEM IN THIS SPACE - AS SOON AS I GET TIME.

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