"Talk about a miracle !"

Co-operating with addicts and their networks

Harry Korman and Martin Söderquist

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Litterature ..... **Fel! Bokmärket är inte definierat.**

PREFACE BY BEN FURMAN

Family therapy has taken several decisive steps since the time of Salvador Minuchin. In his structural family therapy model the assumption was that problems were signs of structural deviations in the family. The assumption was that the problem was not the real problem but was merely a symptom of a dysfunction in the family.

The brief therapists at Mental Research Institute (MRI) on the American west coast didn't agree with Minuchin. They couldn't care less about the structure and dynamics of families. They leaned on the spirit of Milton Erickson and claimed that the problem was not at all a symptom of intra-psychic conflicts or family problems, but was the result of trying to solve a problem in the wrong way. They declared; "The problem is not the problem, the attempted solution is the problem." They rejected a professional culture where therapists spent innumerable hours to diagnose, understand, interpret and think about individuals and families. They thought that the focus should be on what people had tried to do to solve their problem that hadn't worked, to be able to suggest that they should do something else instead.

This radical view made therapy briefer while it at the same time confused other professionals. There was talk about paradoxes and incredible anecdotes were told where therapy was starting to look like old sagas where wise old men told their poor clients to do the weirdest things to solve their problems.

But before a wider public had become acquainted with the fascinating brief therapy a new change occurred. Steve de Shazer and others working at Brief Family Therapy Center in Milwaukee, USA, started writing about these new ideas that they called "solution focused" instead of "problem focused".

The Milwaukee-group disagreed with the brief therapists at MRI. They claimed that the problem was the way one had started to talk about the problem. They had found a new way to talk to people. An optimistic way that built on the future, progress and the clients own resources. They had found a way that fit with the thinking of Milton Erickson: "The patient knows the solution to his problem. Only he doesn't know that he knows." They transformed their ideas into a relatively structured formula, a model that promised results as long as therapists followed what the model dictated.

The group in Milwaukee wasn't the only group to become aware of the importance of language and story-telling in the maintenance or disappearance of problem. On the other side of Earth, Michael White and David Epston had started to write about more or less similar ideas. Some of the people connected to Lynn Hoffman had started to call themselves 'Post-Milan' and expressed that systemic therapy needed to become more humble and respectful. Tom Andersen in Norway agreed and contributed with his ideas about the 'reflecting team'.

The Malmö-group has been brave. They had worked hard to learn structural family therapy, but in spite of their sacrifices they were prepared to set out on a new course when they became acquainted with solution focused therapy. But they didn't do as many others. They did not become Scandinavian copies of Steve de Shazer, but started to develop a style of their own. In the work that Harry Korman and Martin Söderquist

describes in this book, the scent of solution focused therapy is strongly sensed but there are also many other appealing aromas in the soup.

It shows courage to start working with addicts. It shows courage to work with such a radically new perspective as solution focused therapy. It shows creativity to apply the model in a unique way and finally, it shows generosity to have written this book.

Ben Furman
Helsingfors October, 1993.

PREFACE BY VALLE RUNE

When the understanding of a psychiatric syndrome allows specific prevention (so that it deserves to be called disease), it is habitually transferred to somatic medicine (syphilis, pernicious anemia, Huntington etc.). It is an open question if the encounter between the diagnostic syndromes of psychiatry and molecular-biology and the genetics of the future will result in conditions that are well understood and will remain within the realm of psychiatry. Good explanations to a how a psychiatric condition arises doesn't necessarily generate useful help.

Caring for people with psychotic conditions is therefor not the only definition of the core of psychiatry; we could as well talk about the art to help or the knowledge about how desperation is transformed into vitality. Seen like this, the diagnostic and therapeutic focus on the individual should be supplemented with a focus on the interaction between individuals. Above all there is a need for good models for treatment of the individual and her network of important persons.

A modern Anglo-Saxon model of this kind "Solution focused brief therapy", is now introduced for the first time in Swedish textbook format.

I am proud that the authors belong to the Child and Adolescent Psychiatric Clinic of Malmö. As former "addiction-doctor"(?) I am glad that the clinical experience behind the book is built on the clinics program for hard core heroin addicts; "Family therapy with heroin addicts".

The basic concept to brief solution focused therapy is that everyone creates/recreates identity and life moment by moment, using among other feed-back from ones surrounding.

The concept seems self-evident and incontrovertible, even if concepts from the influential, but maybe irrelevant, digitalized world could incite to contemplation.

The same is for the idea that we create meaning in our life by choosing to remember actions/experiences into a fitting own "life-story", integrated in us with the aid of feed-back from important other people.

That a redefined "life-story" creates the possibilities for new actions/experiences follows logically from these concepts. Focusing the content of interaction onto such definitions of problems that facilitate solutions in the present and the future is purposeful.

The value of the model and methodology presented here should be tested empirically and developed clinically.

The experiences so-forth are promising. Try yourself!

Valle Rune
Doctor in Medicine, Chief of staff
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PREFACE BY THE AUTHORS

We are amazed that we today use the same positively connnoted words to describe our work as we did 10 years ago. The differences in what we actually do are so big that it is enough to look at a vide-tape for 5 minutes to see if it was recorded 10 years, 5 years or 1 year ago. But we still use the same words; respect, wholeness, humbleness, faith in people's resources, families are unique etc. The meanings of these words have slowly changed. Because of this we have stopped believing that adjectives can adequately describe what is unique about solution focused work.

We believe that it is when therapists start understanding the basic difference in perspective between working with problems, and constructing solutions that they can realize the possibilities inherent in this different perspective for Klas and Pernilla and Lasse and other clients.

The joy and freedom that we felt in our work, and we've seen other therapists find in theirs, has been one of the things that has pushed us into writing this book.

Another thing has been the clients we have worked with. We have seen that our sometimes unusual questions have helped them find inventive and sometimes even strange solutions to problems that have tormented them for years. We have seen that unusual questions lead to unusal answers and we believe that many more therapists could ask unusual questions.

We hope that this book can inspire therapists to see their work and their clients in a new and different way. We hope that some will find questions they haven't asked before and therefore will get answers they never heard before.

The way to describe our work and a large part of our thinking is based on what we learnt from Steve de Shazer and Insoo Kim Berg. Most of the concepts in the book are theirs and as we have chosen not to burden the book with references it will not always be clear how much we have to thank them for.

We want to thank:

Maria, Anna, Ronny, Bosse, Anders, Kristina and all the others and your families who taught us respect for the strength and courage it takes to win the fight for a life without drugs and alcohol.

Our colleagues from the Heroin-program: Peter Appel, Lars Dannerup, Sonja Edvardson, Kristina Engman, Ing-Marie Hansson, Jehoshua Kaufman, Holger Klintman, Jocelyne Lopez-Korman, Barbro Persson, Valle Rune and Aviva Suskin-Holmquist,

Our supervisors and the people who inspired us: Insoo Kim-Berg, Steve de Shazer, Olof Ulwan, Charles Fishman, Ben Furman, Peter Lang, Ulf Korman, Tilman Furniss, Bernadette Christensen, Sissel Reichelt, Ernst Salomon, Klas Grevelius, Marianne Cederblad, Geza Patkai.

Our colleagues at the Child and Adolescent Psychiatric Clinic in Malmö, Sweden.

INTRODUCTION

This book is based on the experience the authors had while working with heroin addicts during the years 1983-1990. It is also based on experience with other types of addictions we dealt with in our clinical work and as supervisors. The book consists of thoughts, ideas, perspectives and techniques that we found useful when treating different kinds of addictions in out-patient treatment (alcohol, drugs, food, gambling etc.).

The book deals very much with client's lives outside of the "addiction", and their relationships with family and friends and in what ways these people can be helpful to the addict so that he can do other things than use drugs.

For us and the colleagues we worked with, this way of seeing people, the techniques and the way of working have been useful in our work with other types of addictions, in marital therapy, in general psychiatry and in child and adolescent psychiatry, and also in our work when it is connected to the social welfare system.

The book is for you who work in an out-patient setting, which essentially means that you work with clients who live somewhere else than at your workplace. You work either in an out-patient drug-treatment centre, psychiatry, social welfare system, the church, the penitentiary system or in a number of other contexts.

We have limited experience in using this way of thinking in in-patient-settings. Others have successfully used it in in-patient and day-units and have found what is presented here to be extremely useful. We recommend that the model should be tried in many different settings. If it works, it will be noticed quickly. If it doesn't work - do something different.

What and what not

One shortcoming of this approach is that it makes it impossible to diagnose people and human systems outside the therapy room. Therapists working this way do not gather information concerning symptoms, pathology or family structure in a systematic way. This may lead to problems for therapists in their contact with systems where information about pathology and diagnosis are important, like courts, mental hospitals etc.

The information gathered deals with:

- What the "therapeutic system" looks like
- The resources people
  — have — have had, or — will have in the future
- Ideas about what life will be when the problem is no longer there
- What needs to be done by whom, for the problem to no longer exist.

The approach is easy to learn but difficult to apply and it demands a lot of self-discipline.

The therapists responsibility and basic attitude

Clients[1] come to us and tell us about their lives and situations and we assume that what is told at least in some ways mirrors what goes on in their life.

We also assume an effect in the opposite direction. It is not enough that "reality" affects what goes on in therapy. We also believe that what goes on in therapy has effects on people's reality outside the therapy-room.

(If you don't believe this, you don't believe that people influence each others "realities" or at least you don't believe that therapists can influence the reality of clients and you have probably chosen the wrong profession, or at least you have chosen the wrong book to read.)

We believe that there are many different ways to describe a situation. It is possible to view and describe behaviours and sequences of behaviour from many possible perspectives and therapists/social workers/psychoanalysts/family therapists/men and women actively or passively choose to pay attention to certain things and ignore other. The choices made by the therapist/listener are important in that these choices determine the description of "reality" that is made.

It is these choices that make therapists responsible for the "reality" created in the therapy room, and therefore also partly responsible for the reality that clients' live outside of the therapy-room.

Expressed differently we mean that we "co-create" reality together with our client in the therapy-room and what we construct together is important because it can determine when and if the client will develop a solution.

Expressed in another way, we claim that you as a therapist have a responsibility for what you talk about and how you participate in creating the client's description of his reality, and whether it becomes a description that makes it possible to do something about it or if the client is to continue in the same way as before he[2] came to you.

> Magdalena 26 years old, has abused amphetamines[3] intravenously since she was 21. For 7 years and since her mother's death she has an eating disorder problem alternating between self starvation and bingeing. Using drugs is not a problem for her. She tells us that her only concern is her being so tired that for the last 6 years she hasn't been able to hold a job or *"do anything what so ever"*. Her father blames everything on the drug problem so in later years she has withdrawn from contact with him and now sees him only once or twice a week (she used to see him every day).
>
> It's difficult to talk to her. Her voice is thin, almost inaudible and she uses very few words. 10 minutes into the interview she mentions that she is energetic the days when she will take amphetamines. She knows in advance when this will happen. She rises early, cleans her apartment, buys her groceries, pays her bills, telephones her father and puts on her answering machine. We go through these days in great detail and become fascinated by the fact that it is expecting amphetamines that makes her energetic, not the amphetamines! We joke about how

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[1] We have chosen to use the word client instead of patient. The word is a little bit less stigmatising.

[2] We have chosen to write he when we actuallt mean he/she or she/he.

[3] Used in this way in Sweden and has effects similar to cocaine. There is practically no cocaine in Sweden.

she could arrange so that she would have energetic days more often. Again and again we come back to the fact that it is the expectation of amphetamine – a thought – and not the amphetamines that make her energetic. What is her explanation for this?

She tries but cannot find a reasonable explanation. We continue to be amazed by how competent she is on these energetic days when she energetically does things that take other people days or weeks to accomplish. Can she explain how this idea that she will take amphetamines in the evening makes her energetic the whole day before? Couldn't she ask welfare to pay her every day, since these days are energetic days.

She still cannot explain, but smiles cautiously and talks a little bit louder and a little more articulate. We talk about her father and her brother and the rest of her life that has become very impoverished in the last few years, as she sees it because of her fatigue, as they see it because of the drugs. Eventually we come back to our astonishment over what makes her energetic on the days that she will take amphetamines and that she takes amphetamines on her energetic days.

The feed-back at the end of the session is not complicated. *"Everyone blames the drugs and it is difficult to disagree with one's family".* She immediately answers *"They are the only ones I have"* and we nod and continue; *"until we meet next time we want you to pay attention to what goes on in your life when you have energetic moments".*

When she comes back a fortnight later, she has had 11 energetic days in a row, starting when she left the session. The last three she has run out of energy again. But she has not used any drugs. Three years later she still hasn't returned to drugs.

Certain patterns (descriptions that connect events) will attract our attention and our attention will become part of a pattern of events that starts to live a life of its own. The description is part of creating what is described.

Co-operation

Co-operation is one of the primary metaphores we use as we try to describe what we are doing. Co-operation with the addict, the family and professional networks.

Co-operation is concrete. Sitting down with the addict's family, the addict and the professional network and talking about co-operation is not co-operation. Co-operation is not to say that we shall co-operate. Co-operating is possible without ever mentioning that it is what you are doing.

On a concrete level, co-operation means sharing information, respecting and listening to each other's point of views even if they are different, and using other people's knowledge.

When meeting with clients, families, and networks we always assume that everyone is making an effort to co-operate. The clients and the family-members are making efforts to have a better life or at least to do the best out of more or less impossible situations and the professionals are trying to do their job. The responsibility for making co-operation work consequently falls upon us. As everyone else is always trying and co-operation is a mutual endeavor, it is we who must make efforts to find forms of co-operation that fit with the persons we meet and with their unique situations.

We must listen for and adjust our encounter, and what we suggest, to the motives people have for coming to us and to the possibilities that arise from the relationship we develop with them.

BASIC IDEAS

Creating your story

> Therapist (MS): "What are you good at"?
> Cecile: (long pause) "Nothing" - (she pauses) - "I couldn't even handle elementary school".

We carry with us ideas about what we are like and what other people are like and we carry ideas about how our life is developing (or not developing) and we try to behave in accordance with these ideas. At the same time these ideas about ourselves are influenced by our experience. Hence we exist in a circular context where our ideas about ourselves and about others are both influenced by and influences our reality.

Cecile describes the world as she perceives it and perceives it the way she describes it. When she senses, tastes, smells, looks and listens to her surroundings and herself in relation to others she does not normally perceive lines, colours, smells or input from any specific part of her sensory system. She experiences wholeness and patterns. These experiences are interpretations based on her experience and knowledge which are background to her theory about the world and herself.

The theory that Cecile has about herself and about her life, both as an individual and in relation to other people, can be likened to a story or a narrative that she tells herself. *"I am a skillful person",* or *"I always get into trouble"* or *"why do bad things always happen to ME"* or *"everyone is mean and evil"* are all descriptions that help her create meaning and order, and understand what is going on in her life. It is of course obvious that the ideas Cecile has about herself and others, will recursively affect how she behaves.

The story and time

In the story that we continually create[4] in the present lies history, present and future. Ceciles story is; I **am** not good at anything. I **have never** been good at anything and I **will never** be good at anything. Problematic stories often have these features: *"I've always been - depressed - different - to kind - to good-hearted - to dumb - etc., and I will always be that way, and as I am what I am, which is what I've always been, I can not change."*

The story and other people

Cecile's story about herself contains thoughts about herself as stupid, worthless, and a failure. She is someone who has only herself to blame when misery hits her. In interactions with others she continuously sees and hears others confirm her self-image (a

[4] Telling, retelling, adding and subtracting. Every new experience transforms experience in the present, expectations for the future and colours and modifies our memories. The difference is however most often to small to be noticed as a difference.

story in itself). When people are friendly to her she has difficulty understanding it. Maybe she doesn't even "see" it or she gets suspicious and awkward. It's difficult for her to establish close relationships with other people. When she fails in her relationships with others this becomes a confirmation of her story about herself and adds new parts to the old story.

Coincidences or differences

Similar events will be understood and interpreted differently by different people. If an apple hits Cecile on her head while she is walking in the fruit garden it is unlikely that she will use this event to develop Newton's ideas. It is more likely that she will think; *"This happening to me is typical. It's my usual bad luck".* One of us (authors) would have picked up the apple angrily and thrown it far away, the other would have eaten it.

One day Cecile walks in the garden. Uncommonly and without being really aware of it, her thoughts are contented. An apple falls on her head and by an amazing coincidence it bounces on her head, falls into her hand and she catches it. It doesn't hurt and with a small laughter bubbling inside she takes a big bite out of the apple and for a few seconds enjoys the fresh taste. The moment is short and soon she lets the apple fall to the ground while looking shyly around herself. Half an hour later she remembers only the shame; *"what if anyone saw me when that apple hit me on the head".*

Cecile's story about herself is dominated by her idea about herself as victimized, depressed and incompetent. When events occur that do not conform with this narrative she will see them as coincidences or flukes that have nothing to do with her. These events and behaviours do not carry any meaning, so they will pass by without being noticed as different. This has nothing to do with quantity. Cecile can very well do good things for herself 6 days a week and only do problematic behaviours 1 hour a week and her story about herself could still be the same. Differences remain unnoticed coincidences if they are to small or to slow [5].

It is only when Cecile starts creating a new story about herself that these events can be of some importance for how she perceives herself and thus how she describes what she is doing and thus influence what she is doing. *"I can catch opportunities in the air. I can enjoy the unexpected"* etc.

Theory - Change / Treatment

In Patterns of brief family therapy, Steve de Shazer describes what he calls the binocular theory of change. When we look at something with our eyes, each eye sees one image. The left and the right eye do not see exactly the same image as the angle eye - object is not identical. The difference between the images convey another type of information than the images in themselves, which is depth. If the images were identical it wouldn't be of any importance that we had two eyes, and if the difference between the two images were too great we wouldn't be able to create meaning out of the merging of the images. It is only when the images are sufficiently alike and sufficiently different that the requirements are met for the difference to yield more information; depth.

Steve tycker det behövs ett fall här.

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[5] The living frog can be boiled without jumping out of the pot if you raise the temperature slowly enough.

In the encounter between client and therapist a narrative is created that takes its origin in the clients experience of his problematic existence. The client doesn't come with a finished story. He has an experience of the problem but the description, the narrative around his problems and solutions is shaped in interaction with you. **Härifrån och till slutet av nästa fall hänger ihop och kunde förenklas:** This description created in the conversation can be extremely similar to the client's experience and can thus deeply confirm to the client that he has an insoluble problem and this will eventually make him feel deeply understood. No new information is brought forward and without new information the client will not be able to find any tools to start doing something about his problem.

Requisites for change are at hand when the narrative is sufficiently similar to the client's experience to be accepted, but at the same time sufficiently different to bring forth a new and different perspective. If the difference is too small the requsites for change are not met and if the difference is too big there may not even be a new meeting. The client says: *"That therapist didn't understand anything, there was no use in continuing",* or he thinks *"that was the most stupid I ever heard"* and stops coming.

Useful feed-back for the client is when the story is sufficiently similar to be accepted as a valid description of the clients experience, and sufficiently different to open up new perspectives, possibilities and hope.

Even positive, hopeful, and future oriented narratives can be to different.

> A colleague has heard of solution focused therapy and has read an article and has understood that it is possible to focus on the future in situations and in ways that she couldn't imagine before.
>
> She tries with a young girl who sits at home and doesn't go to school and together they dream up a world far into the future, a world full of hope, resources and possibilities. The athmosphere is very pleasant when the girl suddenly says; *"You are trying to make me think of this so that I shall feel even worse so that I'll understand how impossible it is, aren't you?"* It is impossible to reestablish contact with her again during the rest of the session.

A narrative that is both similar enough and different enough is Magdalena page 13.

The difference that makes a difference

"The difference that makes a difference" is one of the favorite sayings of Gregory Bateson, who meant that without knowledge of death, there could be no knowledge of life. To know what heat is, we must know what cold is, etc. All concepts contain differences as a prerequisite for their existence as concepts, either as opposites or as levels on a scale. If there were no differences we would only see light or dark, feel smooth surfaces that never started or ended, hear nothing or a no-sense murmur, and we would not be able to describe any of it.

At least for therapy, for something to be defined as a problem a possible solution must exist. Without a possible solution the problem is not a problem but a fact of life. It may be painful, but will never the less be a fact of life.

A problem is thus a difference that makes a difference, but a difference in relation to what? For the client evidently in regard to his or hers idea about what "not-problem" looks like or how it is experienced[6] - no matter how vague or incomplete.

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[6] In history, the present or the future.

Exceptions

When Cecile took a bite out of the fresh apple she did something unusual and had an unusual experience. As this event doesn't mean anything to her she doesn't think much about it. Yet it was an **exception** to her problem-saturated story (victim, depressed, incompetent).

When asked questions about what she did to *"enjoy" the apple* or what she did to *"catch the opportunity when it came"* she will bring forth answers like *"I don't know"* or *"I didn't think about it"* or *"I just did it".* These expressions are descriptions of behaviors, and even though they are vague and perhaps hazardous they are descriptions of her behaviors. Hence they have the potential to become descriptions that can become stories that bring meaning to the behaviors they are trying to describe. Thus a possibility arises for alternative stories about Cecile's life.

Stories that are built on exceptions have the advantage of being built upon what the client actually did. They can therefore be similar enough to be accepted as part of the client's history and world, but at the same time different enough to make a difference that will open up the possibility for new stories about oneself. These new stories can suggest different ways to see oneself, and thus a possibility opens for clients to do different things than those existing in their dominant[7] story.

Addicts do not abuse 24 hours a day 365 days a year. It's impossible both for economic and time reasons and besides the addict would die pretty soon. The addict, his family and the professionals involved do not see the drug-free periods as important. Instead they are seen as part of the pattern of addiction. *"Things always go up and down. I/he had no money, there was no heroin in town, I/he was to sick to go out and chase drugs or steal"* etc. What could have been a positive drug- or alcohol-free period is not noticed, and will thus not make a difference that makes a difference.

The therapist, on the contrary, pays attention to events and irregular patterns that do not match the dominating (and often destructive) story. The therapist simply assumes that the client does something that is good for him even if he doesn't know it. The therapist therefore asks why the addict didn't do what he usually does; for instance, take something other than heroin, steal to get money, or if he was so sick, had someone else get drugs for him. *Why didn't he do that? How come? What did he do instead? What did he do to resist the urge?*

The therapist's focuses on the choices the addicts had and the choices he actually made. Efforts and willpower is put forward and (eventually) becomes a difference that will make a difference for the client and his network. This type of questioning challenges the client, brings forth new perspectives and thus opens up for change as meaning is created around what functions well, making it something different then just coincidence or chance.

We think it is important to differentiate between **exceptions** and **resources**. Resources are briefly (more further on) everything that keeps the client alive despite his condition, while exceptions are when things happen that are in line with what the client wants (goals). It is thus important that when you inquire about exceptions, think both about what the client is complaining about and what it is he wants help with.

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[7] See Michael White.

Norbert comes with his social worker who has tried for 2 months to send him to an institution for a 30-day AA program for his alcoholism. Nils lost his job because of his drinking and is now, according to his social worker, about to loose his family for the same reason.

In the interview Norbert describes problem with his wife, but he also describes instances of intimacy and closeness, when he, for instance, hugs his wife and gets a positive response, and when the two of them have fun together with their children. This is something everyone in the family appreciates. Norbert doesn't talk about his drinking. When the social worker tries to make him talk about it, he confirms that his wife's worrying is a problem. She constantly worries about when he is going to have his next bout of drinking and her worrying risks spoiling the marriage.

Norbert's complaint revolves around his relationship with his wife, not his relationship to alcohol. His goals for therapy are connected to the relationship with his wife. Out of curiosity the therapist (JLK)[8] wonders whether Norbert believes that a change in the relationship with his wife would result in a change concerning his relationship with alcohol and Norbert nods confirmingly.

The exceptions in the relationship with his wife (the good moments) are further highlighted and Norbert is given a few ideas that he could try as an experiment that could make these moments happen more often. (None of these ideas has anything to do with alcohol, as Norbert doesn't seem to believe that this is the crucial problem (or solution) in the relationship).

When Norbert returns after a week he has discovered what he needs to do to improve his relationship with his wife (breakfast in bed, help the children with their homework, have dinner ready when she comes home from work etc). She is as worried as before about his next relapse, but there isn't very much he can do about it and despite her worrying they have had many good moments during the week.

After another 3 sessions with the same theme over a 3 month period, treatment is terminated. There has been no relapse with his drinking or with the problem with his wife. He says she is satisfied too, and his drinking behavior is no longer a subject of conversation between them.

If the client is complaining about his relationship with his wife, this is the complaint for which we are looking for exceptions. It is impossible to create meaning around behaviors, that are exceptions to our (or the social workers) ideas about the clients problem.

Deliberate exceptions

Deliberate exceptions are exceptions the client can do whenever he wants to. Donald sniffs gas in a compulsory manner and wants to stop. He never sniffs when he is with his girlfriend *"she would beat the shit out of me"*. When Donald doesn't want to sniff he stays with his girlfriend, which he does 2 or 3 evenings a week. He can also abstain from sniffing when he is with his mother, and he is 100% sure that he can abstain tomorrow if he decides to (by being with his mother or with his girlfriend).

Spontaneous exceptions

These are exceptions that occur out of the blue. What makes them happen, when they happen, and why they happen where they happen is a mystery. They just happen. Sometimes an aspect of what is going on is obvious but the description does not have the same character as with deliberate exceptions.

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[8] Jocelyne Lopez-Korman, Avenboken out-patient treatment center, Malmö

Resources and competence

Cecile is good at cooking and likes reading. She is interested in art and she is extremely well versed when it comes to Impressionism. In school she received very high grades in drawing, and she shyly discloses that she paints a little (badly she thinks, and she doesn't understand why her teacher appreciated her so much). Cecile's mother tells the therapist that she has always been very impressed with Cecile's talent in this area. Cecile gets very upset with her mother who hasn't told her this before, but her mother harshly makes it clear that she has shown her appreciation many times.

Even people with "difficult" problems often have many areas in their lives that function well (food, sex, cultural interests, job, etc). These areas are important, because they can be likened to islands of competence and resources onto which exceptions and solutions can be connected to become continents.

Competence and resources is everything in the client's life that is fun, inspiring, delightful, good and useful. In fact anything clients and families do or has the possibility to do that makes them feel good (or at least not worse) and be proud of themselves and eachother.

The therapists basic ideas

What the therapist think is efficient therapy will guide and control both the content and the structure of his conversations with clients and families. His view is represented in his first utterances and his first reactions to what the client presents.

As we think that most of the therapeutic work has to do with the therapist and the client/family co-creating a changeable reality, we think it's good that therapists are not blank mirrors. Therefor we make efforts to make our basic ideas as apparent as possible to ourselves and our clients.

Our first basic idea is that clients and families **do their utmost to co-operate with us** with the purpose to get help in changing what they do in their lives. Our job is therefore to do our utmost to find ways of co-operation considering each family's unique way, conditions and life situation.

> Maria says *"I'm fed up with crying with therapists, it doesn't change anything. Don't make me cry!!!"* and then she starts crying before the therapist (HK) has had a chance to answer. He immediately leans forward and says loudly and remorsefully with an accompanying smile; *"it wasn't me, it wasn't me" and* Maria's crying turns into laughter.
>
> Co-operation is developed in a relationship.

Our second basic idea is that we as therapists have difficulties co-operating with people who come to get help and that we therefore must work very hard to understand what they are telling us about **their goals and solutions**. We try to adjust ourselves and our model to our clients.

> Jonny looks spitefully at the therapist (HK).
>
> "A scale for how I feel. Things like that cannot be reduced to scales!"
>
> "Ok", the therapist answers, and stops using scales with Jonny.

What we do can be seen as trying very hard to understand where the clients wants to go (their goal) and then trying to help them find the shortest way to get there. If this is to

work, the road must be accessible within their repertoire, but it will often not be the road they imagined at outset (had that one worked, they wouldn't have needed therapy).

> Donald's mother calls and wonders if the therapist (HK) can't hypnotise Donald at the next session so that he can tell *"the real reason he is sniffing gas"*. The therapist then wonders if she believes this would lead to him stopping and she confirms this. The therapist than recounts that nobody uses hypnosis like that anymore, but that next week a colleague from the United States is coming to do some training and consultation (Steve de Shazer) and he is one of the foremost hypnotherapists in the world and he has completely stopped using hypnosis because he thinks *"it works better without"*. The therapist also adds that Steve de Shazer is very good at discussing with young people what they have to do to *"stop problematic behaviors"*. She is asked to discuss with the boy and the father and call back and confirm if she wants one of the consultation-opportunities.

During the telephone-call the therapist accepts her goal but indicates an alternative route.

Our third basic idea is that no matter how bad it seems **clients and families do a lot of things that are good for them** and it is our job to find out what those things are.

Our fourth basic idea is that **change is inevitable**. When working like this nothing is ever the same. It is always possible to find differences in the present, the past or in ideas about how the future can be different. With time we have become almost incurably optimistic.

Our fifth basic idea is that **change happens through developing resources rather than treating defects**. This is expressed through a relative non-interest in problems and an insatiable interest in what people are good at.

Our sixth basic idea is that **laughter liberates** and that efficient therapy is often fun. Laughter has a tendency to lure out resources instead of deficiencies. What you can't laugh about you can't take seriously.

Our seventh basic idea is that **the step from the told (expected) problem-free story to actually living it is smaller than usually believed** and it pays off for clients to experiment.

Our eight basic idea is that it is important for **clients to own their change**.

Our ninth basic idea is that **credit for change should be shared** among those who deserve it.

Our tenth basic idea is that **the briefer the therapy the better**.

Jon

> Jon is 17 years old, and his mother phones because Jon has been sluggish, passive and indifferent for a long time and has failed completely in school. He now works in a youth-place[9] since a couple of months and has practically – but not entirely – stopped going there. The police have picked him up with hashish in his pocket and mother has succeeded in making him confess several years of hashish-abuse. She wants help immediately and gets an appointment a week later.
>
> They come together for the first session.
>
> **"What are you good at"?** the therapist (HK) asks and he immediately answers: "Nothing".
>
> "Come on", the therapist says, "what are you good at"?

[9] Arranged and paid by the commune for unemployed people under 20.

With a nonchalant smile he answers; "Sleeping... particularly in the mornings". The therapist seriously notes what he said and adds:

"What else"?

Jon thinks for a few moments, looks questioningly at his mother and says:

"I don't know".

"Hmm", says the therapist, turns toward mother and asks:

"What is he good at"?

"A lot. He is intelligent and sensitive, he can when he wants, he is good at cooking, he is considerate to his friends, he has always been very independent. He has matured early."

The therapist takes notes again, turns to Jon and wonders if he agrees with his mother, and he does. The therapist than asks him what his mother is good at.

"Nagging", he answers, but his voice already sounds a little bit less defensive, and one senses the beginning of a smile there somewhere in the middle of all the sullenness. He continues without any need for encouragement.

"She is good at cooking, and she is *damned* good at keeping order",

"Aha, so your mother is orderly" the therapist comments and notes.

The next question starts with a small lecture. "When things like this happen in families and one finally decides to get some help, this seeking help is a big step. We often see that it is only one of many other things that already started changing. So what I want to ask you is; **what has improved since you called and made the appointment to come here?**"

Mother answers thoughtfully: "That's quite right. He has been calmer, and we talk a lot more". In the discussion that follows they tell the therapist that Jon was very angry during the days that followed his exposure. Angry because mother contacted the parents of his friends, angry because mother contacted the hospital, angry because mother wanted him to go with her to child psychiatry. He then seemed to accept it and became calmer at home. He also went to work every day. He got up in the mornings, with great difficulty, but he has been in time for work every day except one and it has become easier from day to day. Mother also believes that he hasn't smoked any hashish.

The therapist and the family talk for a while about the efforts he made and how he has been able to use mother's determination in a constructive way, and the help she has provided. To questions concerning why he bothers to go to his workplace (just boring and killing him and he just sits of his time), he answers that he has to, as he needs the points to get into high-school next fall. The therapist is pretty surprised by his realism and willpower, and mother has to inform him about her son: "He knows how if he wants to. He matured early."

The therapist thinks it is time to talk about goals and asks the *"miracle-question"* (page 40). Both listens carefully when he asks the question: "Suppose tonight when you are sleeping a miracle happened, and the miracle is that the problems that brought you here was solved. As you were asleep when the miracle happened you wouldn't know it had happened. What would be different tomorrow that would make you think there had been a miracle".

Jon answers: "I wouldn't know there had been a miracle if I was asleep when it happened". He notices that the therapist looks surprised and adds. "I haven't smoked anything now for a fortnight and that's no problem. I'm not saying I'll never smoke again, but I'm not hooked and I'll probably smoke a pipe now and then".

"Aha", says the therapist, "but what about mom. What would she notice that would make her think there had been a miracle?"

Jon answers: "I would be more successful with girls."

The therapist wonders what he means by this, and they talk together about the mysteries with girls. Has he talked with his mother about this, "she is after all a girl"?

"No way"! says he, and all three laugh together at this preposterous idea.

"What do you mean when you say 'more successful with girls'? Do you know when a girl is interested in you?"

"It doesn't happen often", he says, and mother and the therapist unite in playful conspiracy around the idea that he is probably blind when it comes to yearning teenage girls. Maybe it is so, the therapist adds, that the hashish hasn't made this problem any easier to solve as hashish is a drug that tends to turn people inward, paying more attention to themselves than to others.[10]

What would she notice after the miracle the therapist wonders and mother answers: "I would see a boy that was glad in the morning. He'd probably still have difficulties getting out of bed, but he would be glad when he got down to the kitchen. In the afternoon he would tell me something about his day, without me having to pull every word out of him, and he would say something positive about his job. An evening now and then he'd be home, doing something with me. I never see him", she finishes a little whining.

The therapist echoes everything she said except for the last (never sees him), as he notes it. He also checks with her if she means that Jon would answer with less effort on her behalf, or if she means that he would talk to her spontaneously, and she confirms the last. Cautiously the therapist turns to Jon, wondering how this fits for him. Maybe it does but he'll never enjoy that job, but sure it's possible that it can be fun to do something with mom sometime.

"Great", says the therapist.

The therapist wonders to himself, if any of this happens from time to time? Are there any **exceptions?** He asks:

"Does any of this happen now and then, or are there things going on that are in the direction of this happening"?

Mother recounts that for the last few days she has had the impression that Jon is more considerate toward his little brother and sister and there has been much less arguing and fighting. Jon proudly and a little bit shyly adds that yesterday he actually had a long conversation with his 12-year old brother.

The therapist ends the interview with **scaling-questions**.

"On a scale from 1 to 10, where 10 stands for this problem being enormously serious and 1 not serious at all, how do see that"?

Jon thinks for a while, looks furtively at his mother and answers "6".

"On the same scale, what are your chances of getting out of it"?

He answers "8".

"On the same scale where 10 means you're prepared to do anything to solve this problem and 1 means the only thing you are prepared to do is to sit on your bottom and wait for a miracle"?

"6"

The therapist notes, looks in his papers and says he would like a couple of minutes for himself in the corridor. He wants to think about what they talked about, what he thinks of their situation, and if he has any ideas that he thinks could be useful. Before he rises he asks:

"Is there anything important at this point that you want me to know before I go out to discuss with myself, or is there a question you think I forgot to ask"?

They both think for a while shake their heads and he goes out.

When he comes back after about ten minutes to **summarize** the session, they are both very attentive.

"First I want to say that I think it's a good thing you came. This is a serious problem and you are both well aware of the fact that it will take a lot of hard work to solve this problem".

The therapist then turns to mother and continues:

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[10] Here I actually spend 5 minutes being pedagogic around the effects of hashish. My idea was to connect the negative effects of hashish to his complaint. In retrospect I see it as pointing a finger big as a baseball-bat and we all know what teenagers think about pointing fingers. It could have hurt our co-operation.

"I am very impressed with your boy. His open mindedness, his sense for nuances, his honesty and sensitivity and this nice contact he is offering. I agree with you that he matured early, and while walking in the corridor thinking, I got this idea that maybe he has needed this period of hashish-abuse to slow down his development to manhood[11]".

She nods and the therapist turns to Jon:

"I think you are lucky to have a mother who dares show her involvement in many different ways".

He nods and the therapist says he has a task for each of them that he thinks can be of some help. To mother he says;

"Pay attention to when you see that he gets up in a good mood in the morning, when he is kind with his siblings, when he makes a positive comment about his job or does anything else in line with the miracle. Note the time and give him a present 24 hours later without telling him why".

"As for you Jon, till we meet next, I want you to pay attention to whatever happens in your life that you would like to continue to have happen in the future when the problem is solved".

They agree on 2 weeks till next session. The therapist actually would have preferred one week, but mother and Jon agree that 2 weeks is best and the therapist accepts without discussion. Just before leaving the therapist says:

"Think about bringing anyone that you think could be helpful in solving this problem".

Useful ideas

Useful ideas are ideas that have helped us in our work. They consist of a few simple thoughts that help us co-operate with the people we meet. We do not mean that these ideas are the only ideas conceivable in therapy or that they are the truth or the way things should be done. Problem-solution and treatment varies, as everyone is unique. The way to find and describe exceptions and solutions need to be fitted individually with clients, families and therapists. Problems are solved in many different ways and we are convinced that most of the "therapeutic" work is not done at the therapists office but in the clients ordinary environment.

The ideas are grouped in three categories. First we talk about ideas that facilitate for us (and hopefully for you) to establish a working-relation based on co-operation. We call that ”developing fit”. Thereafter we talk about ideas that have more to do with technique, we call that part "method-ideas", and finally we talk about our goals for treatment. We call that "ambitions".

Developing fit

Creating confidence and developing fit is much more than technique. Some even call it art. The following ideas can facilitate the task.

Show respect and humbleness - or - what they don't complain about is none of your business

One of the more important things to think about as a therapist is that it is not your job to change your clients. Most people come to therapy to solve difficulties, not to change their personality. You should be curious, ask questions about the client's situation and accept their way of seeing things. Accepting does not mean agreeing with everything. It means that you do your best to listen to your client, you ask about the things you don't

[11] This last phrase wouldn’t have been part of the message today (1999).

understand, you don't criticize, and you pay attention to what the client handles well. It is the client who decides what he wants to change, not you.

Accept the problem and the goal the client or the family set for the contact with you. When you get ideas about what people **should** change, it is not certain you are wrong, but you can never have your clients'/families' perspective on their lives. It is impossible not to lack in respect for peoples own capacity to deal with their lives, when you try to decide what's best for them. Besides, it's rare that you can change something your client does not want to change himself or herself. One experience we, as many others have had over time is that you can trust that people know what they have to do first. So listen to **their** complaints and their idea about what their solutions looks like. Try to avoid letting your normative and "healthy" ideas take over.

Jon's mother wants help so she can help her son quit using drugs. What he wants help with is not entirely clear, but since he looks proud and glad when he participates in the descriptions of what has changed since his exposure, we assume that he want more things like that to happen in his life. Furthermore he doesn't seem to react negatively to mothers "miracle" and - as a preliminary hypothesis - we assume that his goal and mothers are not mutually exclusive.

A famous brief therapist (Bill O'Hanlon) recommends that you should have an analyst's couch in every brief therapy office, to be used by the therapist every time he gets the urge to define a problem, a solution or a goal for a client. It is important to stay on the couch until the urge has passed.

People have good reasons to do what they do

People always have good reasons for their behavior, even when it seems incomprehensible and crazy to others (and sometimes even to themselves). If an addict does not want to go into in-patient treatment this does not mean that the addict is "unmotivated". It means that the addict has good reasons not to want to. Maybe he or she is afraid to leave town, fearing what might happen to his parents. Maybe he has some previous unfortunate experience with treatment. Maybe he is afraid to expose himself in a group therapy setting, where he doesn't trust anybody. Maybe it simply means that the addict wants to do something entirely different from what others or we want him to do.

When meeting Jon we assume from the positive things he did since the exposure that he wants to have a good life for himself and for his family, and that he is prepared to do something to make this possible. We don't ask why he did all those things, as we don't ask why he is using drugs. Jon may not know how to change his life, or if it is at all possible and because of this he may not seem 100% determined to make the effort. This doesn't mean that he doesn't want to have a good life.

We have never yet met a parent who has given up entirely and who no longer cares for his or her child. Every parent we've met hopes for a good future for their child and, like Jons mother, have been prepared to do anything that has a reasonable chance of being helpful.

It is useful to assume that other professionals, like us are genuinely interested in helping the client and prepared to do what they can. Press and TV sometimes paint pictures of social workers being loathsome figures whose only goal is to take children into custody and make misery for ordinary people. We have worked in child psychiatry and drug treatment for a number of years and we have not yet met any professional that fits this picture. The professionals we have met have always tried to do the best they can,

sometimes in impossible working conditions and often with very little support and backup.

Confirm people as unique

Jon is unique. His mother is unique. The resources, wishes and dreams of every individual are unique. We always assume that every client feels special in one way or another. Almost every addict thinks that other addicts are more wasted, more aggressive, less honest, less smart or… (a number of other adjectives). It is a useful (and unusual) experience for our clients to be seen and confirmed as unique in one or several respects.

Every family has in its own way created patterns, rules and habits. Every family is a miniculture and the therapist should act as a respectful social anthropologist in his meeting with them, which means that he should be curious, observe the unique and pass it back to the family members.

Take difficulties seriously

When we talk to Jon and his mother about goals, exceptions and solutions (and not about the problem) it does not mean that we see their problem as insignificant. We talk with them about the differences between their problems and their goals. These differences we take very seriously and hopefully we meet them in such a way that they understand that we think that none of this is trivial.

Addiction is a serious problem that can – and often will – lead to early death. Even when it doesn't result in death the consequences are very serious; disease, criminality, prostitution, battering etc.

If you obstinately avoid talking about the seriousness, the situation can become very strange. Talking about danger and risks with addicts is not dangerous, they are very much aware of them. Pia for instance says: "I gamble with death every day".

The danger of talking too much about problems is that you risk getting caught by the seriousness. The sessions then become morose and hopeless, and if you can't move on both therapist and client are drained of energy, creativity and ideas for solutions.

What you can't laugh about you can't take seriously. Humor is important in therapy even - and maybe particularly - when the problems are serious and difficult.

Method

Focus on competence and exceptions

Our first question to Jon is: "What are you good at"? Our second question is: "What has already started changing for the better"?

Our working hypothesis is that clients and families already started solving the problems before they meet us the first time. If asked, more than 60% of our clients, announce that there have been positive changes in their life before the first interview with the therapist.

Assume that exceptions to the problem always exist. All addicts stop their abuse for longer or shorter periods of time. All disobedient children sometimes obey. It is impossible for people to know that something is a problem if they don't have any idea of what the no-problem to this problem is or will be.

Assume that the addict has drug-free periods and can resist the urge, at least occasionally. Ask **when and how** he did it instead of asking if it happens.

Assume that the family is doing and has done a lot of different things to help their son, daughter, husband or wife and invite them to describe when and how they did things they think were helpful.

Also assume that the professionals have done and continue to do good things and that they notice when the client shows strength, willpower and courage. Ask them to comment on such things.

Determine the goals

People experience problems in relation to time. The "depressed" client feels that his problem will **never** pass. The client with agoraphobia is not only afraid of that gnawing feeling of uncertainty and anxiety that is tormenting his stomach. He is also paralyzed by the certainty that he will die **when** he walks out onto the square.

On a simplified level all problems can be described as belonging to one of two categories.

There are problems of type "I would like to be able to **do** that or that, but I dare not or I can not", and there are problems of type "I would like to be able to **not do** that and that". (Addiction is most often described as belonging to this second type of problem).

The goal in one case is then to **do** that or that which the client is not doing, and in the other case to **do something different** than the problem (not doing the problematic behavior). By helping people project themselves into the future and imagine (fantasize about) a future without the problem we obtain a description of the clients goal. At the same time we get a description of the difference between the problem and the goal which can help us express the understanding clients sometimes needs to dare take on the hard work for a future without drugs or alcohol.

In the practical reality of every day clinical work you get the impression that when people can connect the idea of the absence of the problem with specific behaviors that are possible for them, this is enough for them to start them doing these specific behaviors[12].

What interests us are therefore goals described in concrete terms. So small they may have happened (be attained) at least in some instances before the session next week and described in such a way that both we and the clients will know if and when they happened. That they occurred doesn't automatically mean that the goals are attained. For this the client also needs to be confident that he can continue to do them. On the other hand goals can never be attained without them happening.

Useful goals are **small, important to the client, described in concrete behavioural terms** and **possible to achieve** in the client's life-situation. The goals should also **require hard work** to be reached**.**

Huge goals lay the foundation for failure and frustration. Therefore small goals are preferable - several small attainable goals in succession instead of one unattainable one.

Useful goals are goals described in **concrete behavioral terms** and described as the **beginning** of something instead of the end of something. It is also important that the goals are described as the **presence** of something rather than the absence of something. These three things make descriptions concrete and make it easy to evaluate whether or not the goal is attained.

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[12] In Tractatus Logico-filosoficus Wittgenstein says "That which is conceivable is also possible" (translated from swedish).

Goals that can't be reached because they are not realistic in the client's life-situation are meaningless, if not destructive within this model. If you form goals that are unattainable you risk increasing the clients sense of desperation.

If hard work is not required to reach the goals, you infer that the client should have solved this problem a long time ago, and he must therefore be stupid since he hasn't solved the problem already.

From this follows that **not abusing** is not a good goal. It is impossible to know for sure when it is reached. It contains no concrete and specific behavioral descriptions. It is not described as the beginning of something. It is of course desirable and for certain it's hard work.

A better formed goal can be: When the problem is solved I get up at eight o'clock in the morning, eat breakfast and go out looking for a job. This can then be broken down into smaller goals (waking from the alarm, etc) or be built upon with more goals (being on time for work).

Useful goals directly related to addictive behaviors often have the form; "saying no thanks to a drink", "arranging for someone else to answer the phone", passing a shop with alcohol with money in the pocket without going in".

Addicts sometimes want to get rid of social workers that interfere in their lives while social workers and families want the addict to stop abusing. It is important to help everyone formulate these goals in smaller steps and more concrete terms asking questions like: "What do you have to do for them to calm down and leave you alone?"

"What will be different when K stopped abusing"? and

"What will be the first sign that will tell you that K started stopping"?

Clarify context and responsibility

Your responsibility for the lives of your clients varies between two extremes. One suggested by the word responding (re-sponding: re-thinking), which essentially means that your only responsibility is to respond to another human being and have as nice and useful a conversation as possible. You don't have any responsibility, and can not be held accountable for anything the client does or does not do outside of the therapy room.

The other pole is that you are in a **state-officer** function. You are investigating child custody cases or you are doing pre-sentence investigations for the penitentiary system and the assessments you do are important for the freedom of your clients or if he or she will be allowed to take care of his or her children etc.

Often you are situated somewhere in between these poles and it is not unusual that you have to move between them.

When you do assessments or take a stand as a person in authority on questions concerning protective aspects for children you have to decide "how things really are". Your context is then one in which a truth exists in the form of "daddy hits his children" or "father and mother abuse so much that they can't take care of their children" or "her abuse means that her children are at risk". These are static descriptions that are essential to settle questions concerning "social control" and it is not possible to get an answer to these questions and at the same time carry out treatment.

It is important that you clarify your context and your responsibility to the client. Many misunderstandings and muddles will be avoided when you are clear about your assignment. Are you there as a person in authority who has been ordered to do an assessment in a child protection case or are you working in an outpatient unit for addicts

where they can seek help anonymously? The preconditions for your session will be dramatically different, and hence the content of your conversation.

> Brynolf and Amelia are brought in because the child protection agency has asked for a child psychiatric assessment. For more than 6 months the social worker has tried to help the couple in many different ways in order not to be obliged to take their two children into custody, but during all this time the couple has continued to leave urine samples "soiled" with amphetamines, benzodiazepines and cannabis. The social worker has informed the child psychiatrist (HK) that the couple just can't understand that there are drugs in their urine.
>
> HK's first question is: "Do you know why you're here?"
>
> Amelia looks true-heartedly at him and answers "Yes, it is to get some help with our children".
>
> HK than explains in great detail and as clearly as he can, that this is not the case. They are in his office because he has to make an assessment as to their capacity for parenting, and he is to write down this assessment and then the court will decide if they are able to take care of their children, or if the children should live somewhere else.
>
> HK then asks what they think their chances are of keeping their children and they answer 100%, to which HK retorts that they must be out of their minds, and don't they know how the courts look at drug abusing parents. After some further negotiation they settle for 50%. HK then asks what they think would increase their chances of keeping the children and after some reflection and discussion they think no drugs in their tests and that Brynolf goes to work would probably increase their chances. After some further discussion they also reach the conclusion that it would help if the Valium disappeared too, despite the fact that it is prescribed by a doctor. It is mostly Amelia who is pushing for this and she calmly points out to her somewhat reluctant husband, that under those positive drug-analysis for Valium, anything can hide. During some time she herself took 600 pills/month so she speaks with a certain authority to which Brynolf eventually bends.
>
> As the couple is leaving, HK summarizes with a point built on the session; "It's interesting that you and the social workers have the same goal." They look at him with some surprise wondering what he means. "Neither you nor them seems to want your kids to grow up with addicted parents". They confirm under calm reflection, go home and start bringing in clean urine samples.
>
> The assessment is then carried out during 4 sessions and is sent to the child protective agency. HK says in his assessment that continued abstinence from drugs is a precondition for the parents to be able to take good care of their children and that abstinence can not be guaranteed. The couple then continues in outpatient treatment elsewhere.

With Jon and his mother the context is defined at outset. The therapist is a doctor in a child psychiatric clinic and the mother and the boy comes to get help with a specific problem. Still you can not neglect the law. When the psychological or physical health of children or adolescents is at risk this must be reported to the authorities concerned (social, police etc.).

When your context is purely one of therapy there are no absolute truths. Nothing is stable and you are interested in all the different possibilities that exist in the future when the problem is solved. You are not even trying to find out how things "really" are, as this among other things doesn't give much information about how things can become in the future.

There is no problem in doing this when other professionals carry the official responsibility, for instance when the referral source is a social worker who takes charge of controlling drug abstinence. It is nevertheless obvious that you must quit your therapeutic relationship when the 15-year old cannabis-smoking adolescent tells you that her dad makes love to her three times a week or when therapy isn't helping Jon.

Jon's mother cancels the second session because Jon has an infection and on the phone she says happily "talk about a miracle".

When they come a week later the miracle has continued. It is as though all the problems have vanished and Jon is satisfied with everything except that he still has not had "more success with girls".

A month later the situation dramatically deteriorates and mother comes alone to discuss the situation. She suspects he started smoking hashish again, and maybe he also started to try "heavier" drugs. She is in despair and very worried that maybe she has entirely lost control over her son. The therapist can not rule out that she may be right and when he has seen her for another 2 sessions and there is no sign of improvement, they agree that the therapist will inform child protection that Jon is in danger.

A social worker meets with Jon and discusses the different alternatives that exist. What we know about that meeting is that the social worker is very clear with what she is forced to do if Jon doesn't straighten up and stops doing drugs. They agree that Jon shall give it another shot with HK and after a few sessions the situation stabilizes.

Don't forget that your world-view is in your questions. Use that knowledge actively. Pay attention to how you formulate your questions and to whom you put them. With simple means you can then quickly and with little ambiguity define context and responsibility.

"I have been asked by your social worker to meet with you to make an assessment for the court".

To the client who comes on his own initiative: "How can I be of help to you?"

To the referrer who comes with the client to the first session: "If this becomes a profitable meeting - what will we have talked about?"

In the investigation situation: "I have been asked by the court to see you to make an assessment of your situation."

The briefer the better

There are many advantages to brief therapy. The message from the therapist is that the client has resources of his own and can handle his situation by himself in the future. The implicit message of long-term treatment is that the client can't do without help, and that the problems are almost irresolvable. We also say that if therapy is not a part of the solution (which shows rapidly), it has become part of the problem.

When the goals for therapy are well-formed (page 27) it's easy to know when they are attained. It will then be obvious to terminate when they are reached or when the client is certain that they can be reached without further therapeutic help. Unclear goals lead to unclear results (for the clients) and long-term or interrupted treatments.

When having therapeutic contact with "multiple goal families"[13] it is better to have several short successful therapies extending over a long period of time, than have one continuing treatment ongoing year after year.

With addicts having problems on several levels - drugs, family, habits of different kind - there is the risk that the addict will replace one dependency for another (treatment, therapist). The responsibility for the client's situation will still remain outside of his own control.

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[13] We owe great thanks to Steve de Shazer and Insoo Kim Berg for this denomination that we use instead of multi-problem families. It has made work easier.

We see therapy as time-limited help to self-help. We see brief therapy as an attitude with the therapist so concerned with respect for - and faith in - the clients' own resources and creativity, that every session can be the last.

The ambition

Clients need to own the change

When a client's life changes for the better and this is connected to the client having done things he didn't think he could do, this is something encouraging, uplifting and beyond all, it is something the client can do again. When the therapist, mother and Jon notices that Jon already started changing his life for the better, these changes will be signs showing that Jon has resources, willpower and competence to handle his own difficulties.

It is always the client's own resources and actions that cause positive change. This will mean that he is not at the mercy of others or to chance or destiny, and he will be more responsible for his own life. If new problems arise the client has a model for how to act.

This means that the therapist shall take responsibility for what goes on in the sessions. If a session is destructive it is the therapists responsibility that this happened and also his responsibility to correct the situation or at least apologize (and thereby take on the responsibility). Apologizing is a respectful way to take on responsibility and something clients appreciates.

To us this implies that when things are moving in the right direction it is the client who shall have the praise, the endorsement and the responsibility. If things go badly it is always the therapist's fault.

Share the merit

Addicts do not solve their problems on their own. Jon has a mother who "dares show her involvement in many different ways". We humans are not islands in an ocean of loneliness. When things are going better it is because people in the addicts environment in some way participate in things getting better. Very often it is family members[14]. It is important that these people are given merit for the changes and that the addict can feel proud of his competent family members, and through this can feel proud of his own competence.

"How were they helpful?"

"What was most important, their support or their confrontation?"

The role of the therapist

From the above it is clear that we see the therapists role as one of a guide or pilot. Someone who knows about finding/constructing solutions and someone who for a short while helps the client and the family notice what is working and finding ways to do more of it. The therapist is not a locomotive pulling or pushing the wagons (client and family)

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[14] When following up former addicts one question is always what they think is the most important reason that they were successful. The most commonly repeated answer is that they had their family's support.

from start to goal. The therapist is a pilot who at certain difficult passes helps the boat find its way and then trusts it to go the rest of the way on its own.

We see addicts and their families as people in difficult if not impossible situations. The help they need is to get some acknowledgment of them being normal reasonable people who wants to do something about their situation. Recognition that they already found solutions to difficult problems and some support and advice that help them do more of what works - even if this at outset seems to be very little.

The role of the team

Teamwork has been the foundation for the evolution we experienced during the years of work with addicts.

With team we mean that a group consisting of one or several people follow the therapists work with the client/family either in the room, or via a one-way screen or via a closed television circuit. The team actively participates by passing on their points of view through telephone calls, by the therapist taking a break to discuss with the team or by someone from the team walking into the session. We are rigorous in making this clear: "We are a team working for you".

It is often impossible to work with a team – most of the work within health- and social service system is done by one therapist or, in the best of circumstances, two. It is neither reasonable, nor necessary, to have a team in all cases. In most workplaces it is possible though to work with colleagues at least one or two half-days a week.

After a difficult period you will find that the team approach means an enormous security in your work and that the team's encouragement and points of view are very useful.

The team has many roles. Some of the more important are:

- Help the therapist observe and notice the clients' resources, competence and strengths. It is easier for team members who follow the session from behind the one-way screen to see nuances and subtleties. It is easier for the team to listen than it is for the therapist. The team members don't have to think about the next question or think about how to react to what the client just said. Team members also have the possibility to write down peculiar or characteristic expressions that the client uses often. Observations by team-members are useful both for concluding and summarizing the ongoing session and for subsequent sessions. Four, six or seven eyes and ears see and hear more than two.
- Help the therapist keep the direction of the session, getting an answer to the questions he asks and not being distracted by everything of less importance coming up in the session. Conversing with people in difficult situations and making the conversation a constructive event in the clients' life is an art that demands concentration, respect and humbleness. Loosing the thread and direction is no catastrophe and happens to every therapist. The team can be an invaluable resource in finding the way back.
- Help the therapist keep different descriptions of reality alive, so he doesn't get caught in one truth – one description. As the different team members are different persons, carry with them different experiences and have different distance and involvement in the session, the same event will be seen differently. The descriptions will be different, ideas can flow and the ambiance can become extremely creative.

Teamwork is not easy. It takes hard work and endurance to respect each other's different ways of working and to find ways to give comments that are useful.
For many therapists it is a relief to know that the colleagues will intervene if things get completely out of hand. This gives more freedom to follow hunches and impulses.

- Help therapists in training to find their way of working. Teamwork is a very efficient learning situation. As a team member you are actively participating in the treatment but you are not obliged in the beginning to take on huge responsabilities. Later when you are in the room with the client it gives a sense of security to have the support of the team. Teamwork in this way trains observational skills, conceptualizing skills and the skills needed to carry on sessions when you work alone.

When it comes to how teamwork shall be put into practice there are two points we like to stress - the importance of assigning responsibility and the importance of a positive attitude.

One of the first days we (the authors) worked together after we started co-operating back in 1983, we had two sessions. In the first, we waited for the other to take the initiative and in the other, we kept interrupting each other. "We can't go on like this" we said to each other, and decided that from then on we would work with one therapist in the room with the family and that therapist should be responsible for treatment. The other one should follow the session through a one-way screen or on TV. It is advantageous to have clear and simple sharing of responsibility when you deal with issues on life and death.

Teamwork stands and falls with the team members' attitude towards each other. The work is awarding and constructive if everyone makes an effort to encourage and support each other and actively see and hear what other people in the team are doing well. In the solution focused model one central objective is to notice and acknowledge resources, competence and exceptions in the clients life. The same goes for teamwork – noticing what functions well for the therapist in the session and what he does well.

Inspired by Ben Furman sometimes we (particularly MS) work with the therapist and the team sitting in the therapy room with the client/family. Some families prefer this, but the most important point as we see it, is that the team become living persons to the client/family. This they become by being active and sharing their observations in different ways with the therapist and the client – phoning in to the therapist, a team member goes into the session and makes a point or the therapist and the team have a discussion about the session where the client observes and listens.

MS has met Rolf and his family for a few sessions in the heroin program (see page 127). On one occasion we had made a triple booking and neither one-way screen nor team was available. It was decided that MS should be the one to have a session without a team. Afterwards MS jokingly told the team that "it was good to decide for oneself and not be interrupted by the team."

At the next session the team participated as ordinary. A while into the session the telephone rings. Mother in the family exclaims: "Ah, you have a team today - good. It sorts of becomes more real then".

Nobody in the therapy-room can avoid hearing the pleased laughter of the team through the one-way-screen.

One final comment on teamwork. In a follow-up study from the child psychiatric clinic of Karlshamn (in the south of Sweden), where among other things the families were interviewed about what they thought about having a team behind the one-way screen, several families complained that the team was to anonymous and that they would have liked to have the team members presented to them. In Karlshamn following this study every team member always greets the families. We are not that radical. We ask if the family members would like to say "hallo" to the team and about half of the families choose to do that.

BASIC PRAXIS

Therapeutic strategies

To listen

Generally speaking all therapy models are concerned with helping clients think differently or act differently. In solution focused therapy this can be achieved by people changing their **way of thinking and describing**, changing **what** they do, **where** they do it, **when** they do it or **with whom** they are doing it.

How are you to know the easiest and most accessible route to achieve change? You can't know but you can listen. It's not that the client knows either but when you listen to how the client describes his problems, his goals, his exceptions and his resources, somewhere in the description there exists hints to what roads are not accessible and sometimes a strong indication to the ones possible.

The human way of functioning is that we tackle problems from how we define them. Is it a bad habit as an expression of a bad character, or is it the drug-effects that has taken a grip on Nils, or is it his bad friends that society hasn't taken care of? Does the wife see her nagging him as the problem and this leading to him withdrawing and drinking?

The details in these descriptions are important as they indicate different ways of thinking about the problem and different expectations of what can be useful ways of handling it (the clients theory of change). In one case, relatives express that the problem and dealing with it is outside of their realm of possibilities and in another a person expresses that her behavior has some importance to the problem and maybe also for solving it.

Listen for what?

A small map for what can be useful to listen for can sometimes be of help:

- What is the client thinking about his problem? Is he himself part of it, or is it caused by other people, by chance or destiny?
- Are there other areas of the client's life where these factors play another role and lead to positive experiences? Is it bad character or unhappy circumstances? Does the client see the solution as clenching his teeth and fighting the urge, or does he think he has to find something different and meaningful to do first? Is it someone else who has to change first? Does Nils believe that his wife has to stop nagging for him to be able to stop drinking? If so, how is Nils behaving the times that his wife isn’t nagging him?
- Does the problem exist only in certain circumstances, with certain people, or in certain places?
- Does the exceptions exist with certain people, in certain places or in special circumstances?

- Is the client's goal vague or utopian (become an astronaut or quit using drugs) or concrete, measurable (describable) and reachable? Can you, if you close your eyes and fantasize, see what the client and others will do that is different at breakfast or when they get up in the morning or any situation the client describes?
- Can you get any idea or description as to whose behavior could be described as the starting point for the image (sequence) that you can visualize?

Don't forget that when you are asking for and listening to these things, you are participating in creating them. It is very common that at the start of a session someone defines a problem as being caused by someone else's behavior and at the end of the session as his own responsibility. Clients being "forced" into treatment can start with having no problem at all and end up with being prepared to do a lot of hard work to get an ambitious social worker of their back.

The conditions for such change to take place is that you succeed in meeting the client respectfully despite the impression at outset that he has come to the wrong place or at least to a place he hasn't chosen by himself.

Kerstin's 10-year old daughter is confident that her problem is solved after two sessions and doesn't want to come back anymore. Kerstin agrees on this but wants to come for her own sake.

She comes on her own and to the miracle question she answers

"Bosse (her husband) will stop being dishonest."

Despite hard work on her and the therapist's behalf they don't succeed in forming a more useful goal for therapy. The problem is that her husband is dishonest, drinks a lot and sometimes gets into rages and tares the house apart (three times in their marriage and the latest 8 months earlier). Kerstin and the therapist agree that this is a very serious problem.

When the therapist wonders how much effort she can imagine to put in to "help Bosse become more honest" she answers weariedly that she already tried everything. "It is really his problem and he doesn't want to do anything about it. I've tried to make him seek help."

The therapist sympathizes with her suffering and explains that he understands how difficult this is for her and has she thought about getting a divorce? Of course she has, but for many reasons it's unthinkable. Ahead of herself she sees a long life filled with lies and suffering and the only conceivable solution is that Bosse changes and if he doesn't they will continue as now despite the fact that it is unbearable. The chances that he will change are no more then 2-3 on a 10-grade scale.

To questions dealing with how Kerstin will be different to Bosse when (and if) she will ever be 100% convinced that he is honest, Kerstin answers that she will be happy. She can not imagine how this will be noticed and she can not answer questions around how Bosse and her daughter will describe her change after Bosse has turned honest (and she will be happy).

She cannot offhand remember a time when she was certain Bosse wasn't lying to her. Maybe when the relationship was new (11 years earlier) and Bosse was more thoughtful and considerate towards her but despite many questions around this, and despite her efforts to find answers she doesn't succeed in describing how she was different towards him at that time. Questions around this theme in the present, the past and the future take up more than half the session and the therapist and Kerstin can't find any answers.

"So if he changes", asks the therapist, "how will you know"?

"I won't" she answers. Together they wonder how they are to know that a change occurred.

The summing up of the session contains a lot of compliments to Kerstin for her honesty and frankness and an idea for a task "that may help us to get some more information on what could be helpful". She is asked to put aside a moment each day to try and remember moments with Bosse when she with certainty knew that he was honest "and what was different at these moments".

The therapist never questions what could be described as Kerstin's view (it is Bosse who has the problem and she only "reacts to it"). The therapist tries to cooperate with her on this premise and Kerstin gets a task that seems reasonably possible to do based on this premise.

> When she comes back to the next session two weeks later, she starts the session by saying "I've thought about Bosse's dishonesty and I have come to the conclusion that he is actually being considerate". She then goes on to describe a new spring in their relationship. He has been thoughtful and considerate and has repeatedly taken initiatives in things that he knows she likes. On a scale from 1-10 where 10 means that the relationship is perfect she is at an 8-9. She is perfectly satisfied if it continues the same way.
>
> "What did you do differently?" the therapist asks, and she answers:
>
> "I didn't nag on him".
>
> "Was it difficult"?
>
> "In the beginning yes, but it became easier and easier as he did more of the things I wanted him to do".
>
> "What do you think of your chances to continue to shut your mouth, for say the next 4 weeks".
>
> "9", she answers.
>
> The rest of the session deals with the new pattern that has the possibility of emerging from the interplay of not nagging - thoughtfulness, and the task to her becomes "continue to shut up, and continue to pay attention to how Bosse answers to this".

In this session Kerstin suddenly sees herself as part of the solution. The therapist can do nothing but follow along and now gives her a task of **doing** something (that she has already started doing).

The example shows how clients can move to different positions in the interplay that is developed in the conversation. At the start, Kerstin's relationship to the therapist can be described as someone who is **complaining** to the therapist about a problem that someone else is causing, and that person should do something about it. In the second session the relationship can be described as if she was a **customer** (someone who has a problem and is prepared to do something about it, or as in Kerstin's case, is already doing something about it). A third possible position is when the relationship is characterized by a person seemingly coming to **visit** the therapist. Most often, this is a visit the client doesn't wish, and therefore the client doesn't present a problem other than possibly the person that forced him or her to come.

Listen how

So what of all this are you to listen for and how do you know what is important and useful and what is not? If you are trying to listen to everything you will gather a lot of information and you will find that you often get to a point where more and more information makes you more and more confused.

What's important is that you very actively listen for the client's/family's ideas and descriptions. Try to create a clear picture of how the client/family sees their situation when the problem is solved. Listen with your entire self. Not only with your intellect and your eyes and ears. Listen for areas where you notice that the clients and families get cheerful and encouraged. Listen for concern and connectedness between people around descriptions of resources and exceptions.

Don't let yourself be blinded by the problem of addiction even if there are people around the addict, and maybe the addict himself, that can't imagine any other solution than

for instance the 12-step AA-program. (If the addict wishes help to implement such a program offer that help: "What do you have to do to go to 2 AA-meetings a week"?) Don't forget though to ask the client how his life will be different when he doesn't have to go to AA-meetings anymore. Don't be blinded by the clients idea about the method.

> Bosse and Stina have worked for a while with solution focused treatment but when Aida, 24, declares that she wants to continue therapy-sessions with them until she can have methadone (6 month waiting-list) they start trying to dissuade her from what they perceive as her goal; methadone. Bosse and Stina are very negative to methadone. They have seen younger and younger people with briefer and briefer histories of drug-taking getting into newly started methadone programs in Sweden easier and easier, and they carry frightening pictures from when they visited methadone clinics in the United States.
>
> In supervision they are advised to bring up the discussion about methadone again with Aida, but they are to stay perfectly neutral in relationship to the methadone and to discuss what it is Aida hopes methadone can help her change in her life. That is; discuss the goals departing from Aida's idea about the road.
>
> It is easily forgotten that methadone is not a goal. Aida wants methadone because she thinks it can help her change something in her life. Instead of discussing with her why it wouldn't be good for her to take methadone, it is more fruitful for Aida to discuss what it is she thinks will be different **when** methadone is of help to her. Observe the difference in discussing **how** the methadone is helping her.
>
> When they do this it becomes clear what it is Aida wants to achieve and within a few sessions she starts doing the things she thought she needed methadone to do. When 6 months has passed and she is invited to the methadone clinic she declines, as she is pretty certain that she solved her drug-problem for good.

Choosing strategy

Choosing strategy is based on how you and your client describe the problem/solution/goal, and from how you evaluate the relationship that is developing with the client, deciding whether you are to help people directly **do** something different or if you will work on only creating descriptions that can lead to different behaviours, that is working on helping them **think** differently.

Consider carefully that no explanation is better than any other and that you'd better find a way congruent with how the client perceives his problem, and congruent with how your relationship with the client is developing. Otherwise you don't stand a chance of them doing what you propose.

Changes starting in exceptions

When you listen for and hear descriptions of exceptions, pay particular attention to how the client describes other peoples involvement. It is common that clients describe themselves as reacting positively to someone else being different. Accept this without challenging it. Expand the descriptions and explore how the client is different, what behaviors he thinks are different, and what behaviors he thinks other would ascribe to him as different in these situations. Take care in accepting that these behaviors are reactions to the positive behavior of others.

If you succeed in creating concrete and relatively well described behaviors you have a fantastic material to choose from when you give tasks. Contrary to the family you are not bound to believe that one thing has to happen before the other. You know that behaviours are linked, connected to each other, and you know that if you can make someone do more

of the behaviors described in the exception the others will do more of the behaviors that are complementary to it. (When one person changes everyone else will change too).

It is important if exceptions are deliberate (page 19) or spontaneous (page 19), as it is important how people see their own resources. Is it within their capacity to do it, is it something they tried before? Are there deliberate exceptions in line with the goal? Can the client do them tomorrow as an experiment to see what happens?

All of this you listen and ask for. With time you will discover that people are very creative when it comes to finding solutions and that you have a lot to learn from your clients.

Changes starting in the solution

The story you create contains a well-formed goal. You will discover that the client is working hard during the session and you will often evaluate the relationship as one of a customer (page 37). It will be natural for you to ask the client if he thinks "it's possible to make a miracle-day tomorrow if he makes up his mind to do that"? and surprisingly often he will answer "yes, sure". Scaling-questions (page 42) are often very useful to clarify how confident the client is.

One obvious direction will be to describe the behaviors of the solution so clearly that the client will know if he did or didn't do them until next session. As a task you can than ask the client to let for instance flipping a coin decide if it is to be a "miracle day" or not, and pay attention to the differences in how it makes him feel and how other people are different on those days. If the client is real certain about his ability to make a miracle day, maybe he doesn't even need the coin, but can decide in advance when he will "make a miracle day" and observe the differences compared to ”non-miracle days”.

Changes starting in pattern-interruption

Often a small element in a description can change and the whole requisite for the solution changes along and peoples behavior change.

> Leonardo's interplay with his father is characterized by incessant quarrels starting immediately father comes through the door at home after work. It's frustrating and tiring for everyone. The therapist (MS) suggests father to do something that will certainly surprise his son.
>
> "1 - Don't talk to him. It always ends up in a fight anyway. Write notes instead and give to him, and then just walk away. 2 - Next time you come home from work, get in through the window or crawl in backwards or something like that and pay attention to how he reacts."
>
> Father found a poem in a journal that he thought expressed what he wanted to tell his son and taped it on the mirror in the bathroom. (As Leonardo washed his hands 34 times a day, there was no chance of him not seeing it). Mother performed the second suggestion. One day on the instant father entered the house, and the boy was waiting for him as usual, she started throwing saucepans and dishes and swearing her heart out. The son immediately took a dive for his room instead of arguing with father and suddenly there was room for a new pattern to emerge, a pattern different from the old arguing-pattern.

Useful questions

Here we will talk about some types of questions we’ve found useful when working with all kind of problems. All the questions are based on the presumption that people have resources to solve their problems and that it is always possible to find solutions.

Progress-questions

When Jon and his mother talk about all the positive things that happened since the police took him the therapist thinks "They already solved the problem, they just don't know it." When clients and families can talk about such "pre-therapy change" the process of change is already on its way and it is the client himself who has taken charge of it. The rest of the session then becomes helping the client do more of this.

A couple in their early thirties comes to therapy referred by the nurse helping them with their newborn. It's their second child and the change has been tough for the woman. The referral source is worried that she will once again go into a puerperal psychosis as she did after her first delivery. The therapist asks what this last week has been like and together the couple recounts that it has been a little bit better. They then proceed describing what has been different. The therapist asks when the changes started and the woman answers "It was when I decided to call here."

We have found that it is often helpful when we can connect the start of change in time to having made the decision to seek help. Not that it's good to seek help (it's much better to have solved the problem by themselves), but because it's simply that when families reached the decision to seek help, this is an expression of the decision to really do something about the problem. Other changes are common after one has made that decision. The rest of the session can deal with who did what that was right and good. A summary and encouragement to continue what works and one or more follow-up sessions (if they wish it) with the same theme is often enough.

Future-questions – goal-questions

A positive and optimistic expectation often leads to this expectation being fulfilled. This is of course not strange and is well known in sports and business. (Positive thinking, etc.)

Focusing on the future is a way to talk about possibilities, distinguish problems from their opposite (not-problem) and talk about the problems and the solutions without increasing the desperation.

The miracle question is of great help:

"Suppose that there is a miracle tonight while you are asleep and the problems that brought you here disappear. As you are asleep when the miracle occurs you don't know it happened. What is different when you awaken?" The most common answer is "the problem will be gone and I will be happy" or something similar and we follow up with; "yes of course, so what will you be doing differently?" We then often get a description of ordinary daily activities and life situations. Many times these descriptions say more than problem descriptions as they describe what the person longs to do and the descriptions are concrete.

A young cannabis-smoking schizophrenic girl answers the miracle-question. Her situation is that she is pregnant with a criminal addict, and shares her time about equally between her parent's home, the mental hospital where she is a day-patient and the man's parent's home where he lives. During the first 20 minutes of the interview she has only talked about how happy she is about her pregnancy, and how much she is looking forward to moving in with the man after she has had her baby. All the time in a monotone voice, a flat face and with practically no body movements. The parents and the psychiatric nurse shake their heads and look more and more to the floor.

She immediately answers "I would be well and my eyes would glitter".

It is the first time in the room that she has said anything about health thus indirectly mentioning that she doesn't feel very well.

The therapist adds: "But your parents are a little sleepy tomorrow when you come down the stairs so they wouldn't see your eyes glittering. What would you DO that would make them think that there must have been a miracle?"

She looks thoughtfully in the distance for maybe 10 seconds, a small smile slowly pops up in her face and she says "I would make an abortion, get myself a job, an apartment, a new man, and I'd stop the relationship with Mike".

The parents, the nurse and the therapist look at her in amazement. Nothing she said prior in the session has indicated any sort of awareness into the desperate situation that she finds herself in and with his chin hanging the therapist can only find "Tomorrow morning???" to ask her, and with a splendid smile she answers: "Yes". The therapist adds; "meeting a new man first and then break up with Mike." She smiles again and says with determination: "Exactly."

The rest of the session is devoted to cautiously examining if it isn't a bit much she wants at once, and how come she is so clear about her situation and what needs to be done. She assures again and again and stronger and stronger that she knows what she wants and that she also has the strength to do it.

One week after she has an abortion.

Other ways to focus on the future are:

"Imagine 5 years into the future and we're here talking about how you solved your problems. What do you tell me about how you did"?

"We find it amazing how you solved your problems and you want to write a book about it. What do you call the book and what do you write in the different chapters?"

"Imagine yourself 3 years into the future and you've solved your problems. You want to invite everyone who helped you in any way. Who do you invite and what do you want to thank them for?"

We believe that the sole most important purpose of future-oriented questions is that they help you and the client form goals for therapy. To accomplish this with some clients it fits better to ask what needs to be different for the client to feel or think that he doesn't need therapy anymore (everyone can't believe in or fantasize about miracles).

With clients that were coerced to see the therapist useful questions in this direction are for instance "What do you think your social worker/probation officer needs to see to think you don't have to come here anymore?"

Exception questions

As mentioned earlier there are always exceptions, moments and situations that are characterized by behaviors connected to goals and solutions rather than to what the client is complaining about. The form for questions focusing on this are: "What happens when the problem is not there"?

As the therapist pays attention to the exceptions and asks questions about them, meaning is created around behaviors that exist when the problem is not there. The prerequisites are then met for the description of these behaviors to become a difference to the description of the problem that could actually make a difference. The client will then be able repeat these behaviors and do more of what he does when he doesn't "have the problem". The solution is then already part of the client’s repertoire and the therapist's job is only to find ways to help the client do more of these behaviors.

Questions focusing on exceptions are, for instance:

"Are some days better than other?"

"How do you know if you are having a good day?"

"How do other people notice that it is a good day?"

"What do you and other people do on the good days that distinguish them from bad days and moments?"

When Jon's mother describes the changes since the police took him, and she describes what will be different after the miracle the therapist asks "Does any of this happen sometime, or do things ever happen that are in line with it?"

Exception questions should be related to the complaint and the goal when those are related. For instance the period drinker who drinks for 1 week every month and wants to be able to control his drinking. In that case one can ask: "Why only one week?" That question will be followed by "did it ever happen that it was only 6 days?" "How do you decide when it's time to quit drinking?" "How do stop your period?"

In situations where the goal and the complaint are not directly related, like for instance Norbert page 19, it is important that the questions focus on the clients goal (and not on his complaint).

Change questions

"What is better?"

"What did you do since we met that has been good for you?"

"What has been going well since we last met?"

"In what ways has this last week been different compared to previous weeks?"

"How come this last week is better than the weeks before?"

"Is this something you did before? - No!!!? How did you get the idea to do it this way?"

"Has he done something that surprised you lately?"

"How many good days did you have since we met? - Only one you say - What did you do that day that was good for you?" or "How come you succeeded in having one day?"

These questions can be varied indefinitely depending on the situation in the session, the relationship therapist - client and the clients' life-situation.

Scaling questions

Using visual-analogic scales is something most people do very easily. Maybe the human brain functions like that.

Scaling questions can be used in every possible situation and in any thinkable way. It is very common for people to think in terms of "either or". You have a problem or you don't. You nag or you don't nag. You drink or you don't drink. When asked to scale the problem you automatically think about what would be more or less on this scale - the problem and the goal become relative. As the therapist then focuses on what has to happen for the client to move one step on the scale, the client is helped to explore new possibilities.

Examples of scaling questions:

"If 100 is that you are your ideal person, how close to 100 are you today?"

"If 0 means the worst you've ever been and 10 means the problem is gone or it's the day after the miracle - where are you at today?"

"If 0 stands for as bad as when you decided you needed therapy, and 10 means you're finished with therapy - where are you at now?"

The number of possible questions is limited only by the therapist's imagination. Scaling questions bring extraordinary possibilities to following up on questions. A few ways to continue:

"What do you have to do to get one step/half a step higher?"

"How will your spouse/your parents/your kids/your neighbours notice when you're one step higher on the scale?"

"Who will notice it first?"

"What will he do or say then?"

"If I asked your spouse/your parents/your kids/your neighbours where they think you are at on this scale - what would they answer?"

"What do you think they see that you don't see?" (when the client places himself lower than them).

"What do you think you see that they don't see?" (when the client places himself higher than them).

Scaling questions are also excellent to clarify wishes and will:

"How important is this relationship to you on a 10-grade scale"?

"If 10 stands for you being prepared to do anything to solve this problem, and 0 stands for the opposite, where are you at today?"

"If 10 stands for you being 100% sure that you are able to deal with the rest of this problem, and 0 stands for the opposite, where are you at today?"

"What do need to feel/think that you can handle to get half a step higher?"

"What do you have to do to get half a step higher?"

When clients present what we think are vague goals, scaling questions are many times the only way to get some clarification of what the client means. Scales for how one feels or how close one is to ones goal means something unique to each client and the therapist doesn't have to understand exactly what the client means. It is enough that the client does.

> Steve de Shazer tells a story of the client who tells him, she has had several days at seven.
> "What was different?" he asks.
> "I felt more sevenish," she answers and shrugs her shoulders.

Coping questions

When you're dealing with chronic situations, for instance long term illness from which one will never get well or acute and serious crisis situations, the questions above do not always fit. A small number of parents are extremely preoccupied with all the suffering the addict caused them, and have difficulties at least initially to think forward. In these situations future oriented questions focusing on change won't fit and may even damage cooperation.

Coping - questions can be an alternative.

"How did you cope with that situation"?

"What did you do to survive the shame?"

"How did you deal with that situation?"

"Where did you find the strengths?"

Through these questions the conversation focuses on how the client or relative did something good and useful, despite a difficult or impossible situation. The questions focus on resources and competence. Through them you can access how the clients found out what to do, how they did it, how it was helpful and how they discovered that it helped.

The summary

Below follows a model for the construction of summaries that clients and families most often profit from. For a thorough description we refer primarily to de Shazer "Clues. Investigating solutions in brief therapy" (1988).

The break

We always take a break (when it is physically possible) before finishing our sessions. We use the break to think for ourselves - or discuss with the team if we have one - what the client said and told us. Usually we write down a summary that we tell or read to the client/family.

We think the break is important. When we return the clients pay close attention to what we say about how we perceive their situation, and they seem extremely attentive to the ideas we have about what they can experiment with, observe or think about until next time.

It is important to be clear about the purpose of the break. It's not easy to wait for 5-10-15 minutes when you don't have any idea what you are waiting for. Often we say as HK said to Jon: "I would like to take a break to think for a moment (discuss with my team) about what we talked about and what I (we) think about your situation and see if we have any ideas that we think could be useful. It will take 5-10 minutes. Is there anything important I forgot to ask about or anything you think I should know before I think (discuss)?"

Most often the clients have nothing to add but sometimes there is a point or two they want to clarify. We then ask the clients to either sit out into the waiting room or we go out of the room ourselves. We then sit down and take our time to make a summary that can be given to the family.

The summary can be seen as a second possibility. When the session has been messy, boring or distressing the summary gives us a possibility to contribute anyway. When the session has been clarifying and hopeful this can be even more strengthened.

Confirm the difficulties

Clients and families need to hear they have a serious problem and that it will take a lot of hard work to solve it. If you reduce the problem into a bagatelle, they hear you say that they should have solved this trifle long ago, and that experience doesn't exactly give more hope that change is possible.

Rather general ideas can be supporting for the family if you don't have a very clear idea exactly what is this family's dilemma. "It's painful to want the best and not quite know what's right", or perhaps more specific "it's painful to want to get close to your child, but not quite succeed as you are not certain of what the kid wants".

> "First I want to say that I think it's good you came. This is a serious problem and you are both well aware that it will take a lot of hard work to solve it", the therapist says to Jon and his mother.

Don't forget that the more specific you are, the more the family will feel understood and confirmed if you're right and the more rejected and misunderstood if you're wrong. If you are uncertain be conservative and non-specific. Don't guess. Rather say to little than to much.

Use the client's own words or concepts. This will show them you've listened.

> "It hurts here when I see him do this", says the father and lifts both hands to his chest.
> In the summary the therapist says: "We understand how much it hurts in a fathers heart when his child has such a serious problem."

If you have very little to say in many consecutive interviews, think about what aspect of the interview you need to improve to increase your understanding of families dilemma.

Positive feed-back

Write down a few positively loaded value judgments about each person in the room. Articulate the advances that everyone or at least most of the people agree upon. Tell each family member about their strong sides (resources and competence) that they themselves or others have said they possess. Once again it's best if you use the families own words.

With Jon and his mother we do something we often do. When we compliment Jon we turn to his mother and when we compliment mother we turn to Jon.

"I am very impressed with your boy. His open-mindedness, his sense for nuances, his honesty and sensitivity and this nice contact he is offering. I agree with you that he matured early".

"I think you are lucky to have a mother who dares show her involvement in many different ways".

Sometimes one can combine: "We are deeply impressed with your son's sensitivity and his ability to think so seriously about his situation. It says a lot about what he got from you."

The easiest is often to be direct:

"We see you as an unusually involved and concerned father and you are really amazingly creative."

"Your honesty when facing the difficulties your son is having has moved us deeply, as the way you are being realistic."

"You are really working very hard to keep your family together and you are impressing us with how well you are succeeding."

Don't be afraid to use strong words. When it comes to positive feedback and compliments, the people you see are not used to receiving it and if you are the least ambiguous they'll hear it. Tell them that you and the team (if you are working with one) are impressed by, amazed by, feels strongly etc.

You have to be very clear with the positive things you say in order to be heard.

Idea

If you want to give more than simple ideas what clients and families can try to do at home until next time (which we hope this book inspires to) we recommend that you read Clues to Solutions. Everybody can use two simple rules of thumb though.

If it works, do more of it

Did you get descriptions of concrete behaviors (exceptions) that someone or other is doing, that is in the direction of the goal or that has been helpful? Ask the people to either observe when these behaviors occur, or if the addict or the family members seem very keen on doing something concrete, ask them to try and **do** these behaviors and observe what difference it makes. Think about the difference between deliberate and spontaneous

exceptions (page 18). The rule is that if you have described deliberate exceptions you can simply ask people to do them, while with spontaneous exceptions you have to ask people to observe when they occur or predict if they will. When people are asked in this way to specifically observe "exception behaviors" more than 80% of the clients will report that they occur more often.

If it doesn't work, do something different

There is rarely any sense in asking people to stop doing something. It sometimes work to ask moms, wives or husbands; "When you feel the urge to nag, shut up!" but these situations are not common and demand a lot of the relationship between the therapist and someone who gets such a task.

It's easier to ask people to do something different: "We have understood that you are extremely sensitive to the needs of your child and at the same time fantastically insightful into how he can use you as an excuse to continue to do drugs. We therefore would like you to pay great attention to when you get an urge to nag, and then immediately grab your coat and take a walk around the block, no matter what you are doing at that moment and observe the effects on him."

Be careful to choose a task that you think the person can perform and the better connected the task is to what you talked about, the better the chances they will actually do what you asked (or an improved version of it).

Do-tasks or observe-tasks

We have found that the classification of the client-therapist relationship into three different categories, proposed by de Shazer and his colleagues, is very useful (page 37). Don't forget that the different categories are not characteristics of the clients but a way to describe the relationship between you and your client in this particular session (or during a part of the session).

Customer-relationship: Clients or family-members who clearly expressed that they have a problem and are prepared to do anything to solve it. These you can ask to **do** something.

Visitor-relationship: Clients or family members who don't have any problem. You have received no answer to the miracle question, and when you asked who insisted they should come (if you did) the client was either evasive or told you that it was the probation officer, the social worker or someone else who set it as a condition for something. With these clients you talked about what they are good at, and the nice and useful things that exist in their lives. In the relationship they are developing at this point, it is clear that they are not thinking about what you can do for them. Giving them any form of task would be totally foreign to the relationship (too much difference) and would only make it clear to them that you are just another fool who didn't understand anything. Just give them positive feed-back for the competence and the resources they've succeeded in telling you about and if they want – and you want – set up a new appointment.

Complainant-relationships are just as unstable as the others. Depending on how your relationship is developing people can oscillate very quickly from being someone who just paid you a brief visit, to someone who is behaving as if he had a problem he wants to do something about. Your interactions have great importance for the direction in which the relationship will develop. It's very easy to turn a complainant-relationship into a visitor-relationship. It's enough to tell them that they should change or that they **ought** to take on some kind of responsibility for the problem. Don't forget that "complainant" is only a way

to describe the relationship with you. People can very well behave in one way towards you and then go home and behave differently there. You don't have to shame them for that. Look for instance at Kerstin page 36.

In complainant-relationships you can ask someone to pay attention to in what situation the desired behaviors occur. Both with themselves and with the people they think should do something about the problem. They can even be asked to observe such behaviors with themselves that could lead to the desired behaviors of others, if during the course of the session they had ideas what these behaviors might be.

One simple rule we've found useful is that when we are uncertain when assessing the relationship, we are always conservative. That is, if we are in doubt about whether someone will perform a "do-task", we content ourselves with an "observation-task". If in doubt about an observation-task; then no task.

Is there a goal?

There is a goal described in behavioral terms:

Consider the relationship first (customer or complainant) and ask the client/family members to observe or do the behaviors described. Be concrete when describing the behaviors you want the client to observe (if complainant) or do (if customer) (look at Jon page 21 for an example). Both you and the family should know if the behaviors in question occurred before the next session, and if they did, if the client thinks things are going in the right direction.

There is no goal

This can mean that there is no problem, and this probably means that the client came to the wrong place or hasn't chosen to come. Treat the client as a visitor; respectfully and friendly. Always give compliments. Acknowledge difficulties and suffering if you understood something about the client's dilemma. Do not give any tasks.

The goal is vague and of the type; better communication, happier etc.

It is wise to make up ones mind about what the goal looks like before the break. When the goal is vague it needs to be made as clear as possible with scaling questions. Scales can then be built into the task in different ways. (Predict how high one will be on a certain scale the day after. Think about what's special on the days that one is at 8 on a certain scale, etc.)

Be thorough with the compliments and the confirmation. Prepare yourself to find out at the next interview more about what the client or family hopes to achieve through therapy. The first of the tasks below can be of great help to help you and the clients find out what the vague goal stands for.

Two useful tasks

"Until we meet next time I want you to pay attention to things you do or that happen in your life that you would like to continue to have happen in the future when the problem is solved. Note them in such a way that you can tell me about it next time." (This task is called the formula first session task).

"Until we meet next time I want you to pay attention to what you do when you resist the urge to do drugs (drink, binge etc.). Note it in such a way that you can tell me about it next time."

Don't be shy when you give tasks. You just explained that it will take a lot of hard work to solve this serious and difficult problem and the client and the family nodded all through

your summary. If you are shy here this means you're not taking yourself seriously and then the clients wont take you seriously either.

MEETING THE ADDICT

The addict is the expert on himself

The therapists context

Your context is important since the client on the basis of his ideas about your context will interpret your questions.

"Is it possible to get pills to sober up (or detox) in out-patient care?"

"Can one get sick-leave and on what conditions?"

The simple question: "How can I help?", can therefore lead to very different answers depending on the clients ideas about your setting.

Many people have intuitive knowledge about this. Many of us who have worked in treatment units or institutions within the mental-health service, has more than once tried to show clients that we are not loyal to our units ideology. In an often desperate attempt to escape the restrictions set by our context, we have tried to establish relationships different from what is customary within the unit. On some rare occasions we may also have succeeded, and on some very rare occasions an effort of that kind has changed the direction and/or ideology of an institution (Barbro Sandin, Frida Fromm-Reichman, Salvador Minuchin).

Different units make different demands on clients. Think about the traditions at your workplace. Think about the differences in what clients expect when they come to you if:

- You work in a detoxification-unit that for many years tried to prioritize addicts with a fare chance to continue into long-term treatment, and secondly, for life-saving purposes has taken in extremely worn out patients.
- You are a physician in a hospital-based unit for infectious disease with a rather generous attitude when it comes to trying outpatient detoxification with ”motivated” patients.
- You are a social worker in a commune that subscribes to a large number of places in an institution using the Minnesota-model.
- You are working in an outpatient unit with a strong bias towards doing brief solution-focused therapy with addicts and their families, where clients and families can seek help anonymously.

The client’s context

As we mentioned earlier clients can come to you for many different reasons. One can want to stop abusing drugs or alcohol and do something different in life. Often however it is other things that make clients seek treatment. More or less clearly expressed coercion from family or professional networks, increasing debts with threats that forces the addict to withdraw from circulation for a while, etc.

This is no problem when you are respectful and listen to your client. It only becomes a problem if you assume that the client came because he wants to do something about his addiction, and the client has other more important things on his mind. If you don't listen carefully the client will not be able to talk to you about what is bothering him and will not — at least with you — be able to construct solutions to his problem.

Accept the definition of the problem

Accept the client's definition of the problem, whether it has to do with the abuse or not. Be careful to respect the descriptions even if you see them as an excuse for abusing. "I take amphetamines to cheer me up because I'm so tired," or "Life is so dull". Accept the definition even if you understand the problem as an effect of the addiction: "I would like to be a better mother", "My children are so difficult". Don't connect the problem to the addiction, let the client do it if he wants. Accept that some clients never make the connection. Our clients do not need help to moralize – they are very good at that themselves. Pay attention to when you get irritated or don't feel curiosity. Remember that **everyone is doing the best they can**.

Accept vague problems like for instance: "I get so much social problems from my drinking/abusing," but ask the client to be specific: "How?" or rather: "Problems to who? Is this a problem only for you or are there other people who feel the same way?"

"Would your mother agree or would she say something else?"

When you listen with your entire self you will notice when the problem/goal is relevant to the client.

Assume that everyone is always doing their best

This idea is practically a precondition for developing an alliance based on co-operation. It will also help you and the client describe resources and competence and it will help you to respect and maybe even like the client. If you can not find good things that clients do in their lives; **you** will have to make more efforts to be curious or refer the case.

Accept clients that are high or under the influence

When we started working with addicts our attitude was that addicts came to therapy to stop addictive behavior. We saw detoxification and sobriety as something that should be the result of treatment - not a precondition for treatment so detox before treatment seemed absurd.

Later on, many addicts told us that detoxifying had never been a problem for them. They had done it many times. For them the problem was how to avoid getting high again. The reasons for us to accept to see clients that were on drugs or clients that were high have thus differed over time but the result is the same.

Our experience is that when sessions are interesting enough, the addict will make efforts to understand what is going on and try to get something out of the conversations. Sometimes he will have to reduce his abuse drastically to achieve this and does that.

Don't take anything for granted

We ordinarily have some information about the client before the first session. Assume that the descriptions made are not valid. The social-worker who made the referral said the girl was extremely motivated to stop doing drugs, and three minutes into the session you

find out that her concern is that if she doesn't quit drugs yesterday (?), her baby will be taken into custody the day after tomorrow.

Don't take anything for granted – ask the client!

Starting the session

We all have different ways to start a session. Use yours in a way that you are comfortable with. Consider that when clients come to you the first time they may not have made the decision to stop abusing, but there is often a desire in that direction. Also consider that motivation for change is not a characteristic within the person but something that grows out of the interaction between you.

"What makes you seek help here now?"

"How can I be of help?"

"Imagine this will be a useful conversation for you - what will we have talked about in an hour?"

Why is the client consulting now?

Pay more interest to the present and future than to the problem and the history. **Listen** for what the client is saying and how he is saying it. Try and get a **dynamic description** of the present.

"What is it right now that makes you in your unique situation seek help here today?"

"Who else is involved in this decision to seek help?"

This is more useful information than with what, why and how the addict has been getting high or drunk.

A dynamic description of the present can be for instance:

> "My girlfriend can't stand it anymore. She has made it clear that if I don't quit now, she moves out."
>
> Or:
>
> A fifty-year old alcoholic comes to the Alcohol Clinic's emergency intake.
>
> "What's your problem?" the doctor (HK) asks. The man is very drunk, more falls into the chair, than sits down, flings his arms out in a gesture of resignation and answers in a thick voice: "My parents can't take it anymore."

Some clients seem to come to get a break from the monotony of prison.

> Rolle is actually very clear but the therapist (HK) has difficulties believing what he is hearing.
>
> "It's boring in prison and this suggestion from my social-worker seemed a nice break. Stop doing drugs? No, I don't want that. Do something different? What life would look like without drugs? I can't imagine. A miracle? Miracles don't exist.

Some people don't seem to know why they've come or come because of coincidence.

> Lisa, 30 years old, with moderate abuse comes because she is accompanying her boyfriend to his first session. It is only that he hasn't shown, and yes, she has a small drug-problem, but that is not why she is there.
>
> "What does you life look like?" asks the therapist (HK). "Well", answers she, "not to bad. I live an exciting life. I have creative and artistic ambitions and it is not possible to create without suffering."
>
> "Who worries about you and thinks about how you're doing?"

"Nobody!" she answers, but adds: "Of course my parents are wondering but they don't know." Thoughtfully she continues: "Maybe my older sister is worried as I told her the day before yesterday that I am using drugs".

"So you finally told your family. Is that because you want to change something now?"

"Well". She thinks for a long while, looks thoughtful and says: "Not the heroin, but perhaps smoke a little less pot. It makes one so out of it."

What is the client good at?

The easiest way to find out is to ask: "What are you good at?" Sometimes the client wonders if he got the question right: "What **I?**... am good at???"

Very often you get a nuanced and multifaceted description even from people who are not used to thinking about such things. Almost every time a friendly and relaxed atmosphere develops that facilitates cooperation.

Be thorough with this question. Don't worry if the client has difficulties answering. Ask what mother, father, lover, child and wife would have answered if they were present. Ask about these peoples attitude even if – and maybe even particularly if – the client has no difficulties talking about his own resources and competence. The earlier you start talking about the family in a positive way, the easier it will be for you and the client to use their help in treatment.

Ask what the client used to be good at, and what he thinks he can be good at in the future. Go for the future, the network and life, and get that into the room with you and the client. If you have difficulties in the present – use the future and the history. Take great care in commenting strengths and resources, and if the client seems more alert when talking about how a certain person sees things, ask more about what that person would say if he or she was present.

Pull the network into the conversation in a positive way

That is talk about resources, competence, care and love in the network.

Who cares about you and how do they show it

Ask who cares, or rather:

"Who worries about you?"

"Who else?"

"In what ways have he/she/they tried to be of help?"

"Who will notice **when** it gets better?"

"How/what will they notice?"

"How/what will you notice on them when they have noticed it?"

Ask how these people have been helpful before.

Following up these questions quickly inform you about resources, competence and care in the network.

Don't accept "no-one cares". Ask what mother, father, siblings and grandparents think about the situation.

If the addict answers that they do not know anything (which often happens if this is the first question you ask in the interview), ask what they think he is doing, and inquire in detail what he thinks they think he is doing. Then ask in detail about his care and concern for his family. Evidently he doesn't want to upset them by telling them he is doing drugs or abusing alcohol.

"Don't you want to worry them unnecessarily?"

"Who will be most in despair when/if they find out?"

An alternative question is:

"If they knew about it, what would they think/say/do?"

Try reframing critical depictions of the network in terms of: "So that is how they are trying to help you?"

"Dad is fighting with me all the time" — "Aha, so he hasn't given up hope that he can make you understand".

Or: Mother is nagging all the time" — "Aha, so she is working hard on trying to reach you?"

Possibilities to vary these reframes are indefinite, and most addicts gladly accept alternative explanations for their parents' sometimes pushy behavior. Especially effective language seem to be:

"They haven't given up hope."

"They seem to stick it out despite all the crap you did"

"They really must care very much as they haven't thrown you out yet."

"So you haven't let them help you."

Once again; you and the client will most often be spared of these difficulties if you start off by talking about what the client and his family are good at.

Who do you care about and how do you show it?

If you have done the above first you wont have to ask this question at all, as the answer will be obvious. At this point it may be wise though to make it clear to the addict that you understand that he is making efforts not to hurt the people he loves, even if it is obvious that he is not always successful. Sometimes it's enough to say, "You and your mother are really very close".

Sometimes more is required.

Define the goal

The miracle question

We've already talked about the miracle-question. Our experience is that it is good to ask it in a special way and progressively modify wording and intonation till it fits one's personal style. One way to frame the question, which we found, works for many therapists is, "I have a difficult question", look thoroughly at the client and check that you have his attention. Continue with: "Suppose we sit here and talk, and after this conversation you do what you ordinarily do and tonight you go home and go to bed and you sleep. Then, during the night while you are sleeping a miracle happens. (Wait for a nod) And the problems that brought you here disappear. But since you are asleep when the miracle happened you won't know it happened. (Wait for nod) What is different (what do you do differently) tomorrow that will make you and others believe a miracle happened?"

Acknowledge and validate descriptions like: "I would have better self-esteem",

"I would be happy",

Then explore what the client means. The simplest way is to stay calm in an interested way – sometimes for several minutes – and ask only: "What else?"

Then if necessary help the client be more concrete: "How do other people see when your self-confidence is a little better?"

Some clients need more help: "What do you mean by better self-confidence? Some clients I met would have meant that they'd dare stand by the window when there is a thunderstorm instead of crawling under the table. What do you mean?"

Reflect on the fact that labels signify different things to different people, and that labels are simply a way to categorize different behaviors under a common word like; depressed, anxious, unsure, phobic, etc. It is always good to break these categorizations into the parts that are specific for exactly this client. This is particularly obvious when clients use words that are not exactly correct. A young man seeks psychiatry because he is *depressionated.* What he means only becomes clear when he describes what he is doing on the days that he is not *depressionated*.

Variants of "the problem would be gone, and I would be happy, in harmony, drug-free and very wealthy", are possible first answers but are almost always followed by more realistic descriptions if the therapists simply waits without answering.

If "what else?" doesn't lead on to more elaborate descriptions, follow up with: "Ok, so when you are happy, harmonious, drug-free and very wealthy, what would you do differently? How will other people notice a miracle happened by what you do tomorrow, without you telling them that the ". Try to get concrete descriptions of daily activities and situations.

Be extra curious at this point, as your curiosity will help the client to be creative. Think about the fact that just imagining a future without the problem is a process that creates possibilities. Don't give up easily. The descriptions you and the client will create are descriptions that show in what direction the client wants to develop.

If the client shrugs his shoulders, looks at you with contempt and says: "I haven't got the slightest idea!!" Well, maybe it's time for you to make up your mind and decide that you haven't succeeded this far to establish a relationship where the client is prepared to say that he is willing to work hard to change his life and is prepared to follow your advice. Content yourself with having as pleasant a conversation as possible. Find out what the client is good at, and terminate the session by giving compliments for that. If you do this in a nice and respectful way, and perhaps adds that the client is showing extraordinary strength by not letting himself be pulled into god knows what crap, there is a chance that the client will want to come back. If so it might be possible then to establish a relationship where the client expresses that he wants something more.

If the client answers that there are no miracles, or something similar, you can answer: "You are right. There are no miracles. There is only hard work, so what would be a sign tomorrow that something is happening and that things are moving in the right direction, that is, the direction that's right for you?"

Another alternative that works surprisingly often is: "No there are no miracles, so pretend." Don't forget that clients put a lot of effort into trying to co-operate with you and they make efforts to answer even the weirdest questions. Many clients answer the question: "Ok, so if you knew, what would you answer?"

It is very common for addicts to give very useful answers to the miracle question and other future-oriented questions. Answers that clearly show what they think they will do differently once the problem is no longer a problem. Often it seems by the way to be exactly those things the client need to do not to abuse whatever he or she is abusing.

Conceive of the miracle question and other future-oriented questions as questions that orient about the goal and try and get descriptions of these goals that fulfill the criteria for useful goals (page 27).

"I would be sober when I see the kids. I would pass a liquor store with money in my pocket without going in. I would answer no thank you when Nils asks me if I want a drink."

Agneta will wake up happy in the morning, go jogging before breakfast, eat an ordinary breakfast and then go out and look for a job.

Ingrid would take care of her kids in the morning. Make breakfast, have fun with them, so they would go happily to school and don't argue with each other all the time.

An indication that a miracle-answer is useful is if you can use the same phrasing and ask if it ever happened.

"Does it ever happen that you jog before breakfast?"

"Does it ever happen that you are sober when you see your kids?"

"Does it ever happen that the kids go off to school joyful and happy?"

Don't do this until later on in the interview though as you and the client risk getting caught by the history instead of creating the future.

A word of warning. The miracle-question is not a miraculous question that solves any problems. It is only one way among many to start a conversation about what the client thinks will be different when he no longer needs treatment. For some clients it is as effective to ask: "What do you think or believe will have to be different in your life for you and others to think/feel that you don't have to come here anymore?" or ”How will you know that it has been helpful coming here?”

How will other people notice the miracle?

Always explore how other people will notice when "the miracle happened" or "when the problem is solved or on its way to be solved".

Start from the people you already talked about in your questions:

"What will your mother/father/sister/wife/children etc notice that is different?"

"How will you notice on them that they have seen the change?"

"Will your children fight less with each other when they are less worried about you?"

This part of the interview is particularly important when the clients’ attitude is characterized by the idea that other people have to change for the client to change.

Developing (deepening)

The purpose of developing is to explore and develop the clients’ options. Useful questions at this point are questions about exceptions, pre-session change and scales.

Exception questions

These and the scaling-questions below are questions that build on the miracle question and other goal-related questions. That means: You should have paid attention and listened closely to the clients’ ideas about his future, so that you can weave in his ideas and phrasing in the follow-up questions.

The client says that the morning after the miracle she wakes up alert and joyful. Takes care of the children and jokes with them so they go to school alert and happy.

After a number of "What else?" from the therapist leading on to more complex and detailed descriptions of how the children will behave differently towards each other and towards mother, the therapist asks: "Does it ever happen that you joke with the kids in the morning?"

"Last Friday," answers the client.

"Were they happy?"

"It was a huge difference. When I am in a good mood and feels well in the morning, they don't fight with each other.

When clients answer relevant future oriented questions, the answers will be related to the clients' own experience and the clients' own ideas about what will be different when the goals are attained.

The problem always exists in relation to something that the client can perceive as an alternative. It is your responsibility to ask questions that makes the client examine these alternatives.

Pre-session Change

Behaviors or events that we called exceptions can be signs of "pre-session change" if they are relatively new.

The mother in the example above could have been asked: "Last Friday when you woke up early and prepared breakfast for your kids, is that something new since you decided to do something about the problem and called to make an appointment?"

It is very common for addicts to come sober or detoxified to the first session. It is quite natural to ask how they did this: "How did you do it to come here sober/detoxed?"

Sometimes pre-session change can be rather dramatic or can at least seem so.

Roger is 27 years old. He has abused amphetamines rather frequently for many years and is in a detoxification unit since one week. He has agreed to be interviewed by a consulting therapist (Steve de Shazer) and comes to his first interview.

During the interview it appears that no one knew about the addiction before, and that it is not until now that he told his wife, his children, his parents and his employer.

Roger is very optimistic about his future. Ahead he sees more closeness with his family and perhaps with everyone, as he opened up to a lot of people and got a lot of positive response. He thinks that when the problem is solved, he and his wife will help each other more with the children, he will exercise more and he will devote more time to his old interest in lightweight aircrafts.

Roger is very hopeful. He says his life changed when he contacted the detox-unit and he is *so* grateful to be in treatment.

Someone in the group behind the one-way screen groans loudly and exclaims: "He is so naive!"

The therapist and Roger together build concrete descriptions around what will be different in the future and eventually the therapist asks what of all this that is already happening a little bit.

Roger then recounts that since he contacted the detox-unit 6 weeks ago, almost everything already happened and he even bought a building kit to construct a 2-seated airplane. He says he knows exactly what he has to do to continue what he already started – someone in the observation-team remarks that he looks surprised while saying it – and he is more than 70% sure that he will succeed.

The session is terminated with compliments from the therapist and the team over how far Roger already got and with a task. He is to think about what he has to do to rise to 80% until the next visit in 2 week.

When Roger wanders back to the detox-unit he says to the accompanying staff: "Damn it, that was a smooth bastard!!" The day after he unexpectedly discharges himself from the unit.

2 weeks later he comes to his appointment, but when the therapist comes to bring him in from the waiting-room, he explains that he only came to cancel his appointment. He doesn't need it because; "that guy from America, when we talked. It was as if he put out rails and now it's just straight ahead."

Scaling questions

When you have looked at exceptions, pre-session change and defined the goal it is often wise to sum up the situation in more global terms.

Actual-situation-scale: "0 means the worst situation ever and 10 means the day after the miracle. Where are you at today?"

Confidence-scale: "10 means that you are 100% confident that you will solve this problem and 0 means the opposite. Where are you at today?"

Effort-scale or prepared-to-do-scale: "10 means that you are prepared to do *anything* within your power to solve this problem and 0 means that the only thing you are prepared to do is to sit on your but and wait for a miracle. Where are you at today?"

"Hope-scale", "chance-scale", "others-prepared-to-do-scale" and "close-to-goal-scale" are other useful scales. Once you start using them you will find more.

If the client is low on confidence but seems to want to do something about his problem, it can be wise to ask: "Who shall we call in case you have a falling-out, and stop coming here because of that?"

How will we know when treatment is finished?

These are questions that fulfill at least two purposes. First they help clarifying if the goals are concrete enough to be useful to the client. Secondly you give the message that therapy will not be eternal, and will end when the goals are attained.

"What do you think you will have to have achieved to feel that you don't need any treatment anymore?"

"What do you think your mother/father etc will have to see to think that you've gotten over this problem?"

"When can we quit?"

"What will you notice on them (nod or point to other people present) when they think the problem is solved?"

With clients who have formed vague goals it is important to remember answers to the different scales used. Changes on these scales can sometimes be the only way to know if treatment is of any use.

Ending the session

When ending a session we want to feed back our understanding of what the client told us and we want to try and bring some new perspective. We need the break to think about and discuss with our team or ourselves what the client told us, but the break is also there because we want the client to listen attentively to what we are saying.

"I would like to take a break to sum up how I see your situation", or

"I would like to (usually) take a break to think through how I understand what we have been talking about".

See pages 44 - 48 about the summary and see Jon (page 21) for an example that fairly well describes an ordinary first session.

MEETING WITH THE FAMILY

The parents are the experts on their children

Man is his relationships

Everyone is part of larger contexts and the most important of these contexts, at least in the western world, is the family.

Being a social creature means co-existing with other people. One is ones relationships, not an isolated planet. Everyone is someone else's son or daughter, married to or lives with someone, has children, is friend to someone and is influenced by these people as well as influences them.

We believed for a long time that addicts were outcasts without contact with their families. After having read among others Stanton and Vaillant we began to understand that addicts have a lot of contact with their parents and siblings, but we were still skeptical – was it really like that in Sweden too?

At last someone asks me

> The therapist (MS): (Telephone): Hi, my name is MS and I work with addicts who wants to quit using drugs. I have been talking with your daughter for an hour and she wants to stop. I have understood that you are a very important person to Angelica and I would need your help. Would it be possible for you to come here Friday at 10 am.
>
> Mother: (Takes a short breath, sighs deeply and answers:) At last someone asks me. Of course I'll come.

Before I (MS) called up mother I had talked for one hour with Angelica 22 who had been using drugs for 8 years. In later years heroin. My mind was set for a long and complicated motivational session and I had prepared myself carefully.

Nothing I thought before the session was correct: Angelica told me openly and in detail about her life and her addiction and she immediately answered yes to my suggestion that her parents and siblings should participate in treatment this time.

I called mother who immediately accepted to participate. The father wasn't available so I asked Angelica to tell him I was going to call him. When I reached him the day after, I introduced myself and before I had the time to say anything else he said: "I know. What time was it on Friday?"

In less than an hour I had agreed with Angelica, her parents and siblings to meet for a session 2 days later. I had also agreed with the social worker (who participated in the session with Angelica) on how we were to co-operate and we were both in disbelief about it all. "This was to easy – there is something fishy about it. It must be coincidence," we said to each other.

Angelica was the first addict we asked if she wanted her family to help her quit doing drugs. To her and her family it was obvious that this was the way it should be done. To addicts, their parents and siblings it is natural and obvious that they should participate in treatment – if they only get a chance.

Dependency and loyalty

Addicts are extremely dependent and loyal to their parents and siblings. Some of the addicts we met have been in institutions where they weren't allowed to stay in touch with their parents at least in the beginning of treatment. They are often angry with this and they often stayed in touch secretly anyway. Parents have described how they have been set aside and how they felt questioned and criticized. As the parents and siblings are so important for the client, this is probably a gigantic mistake. The families are the ones who knows the addict best, they know how he functions when it's good and when it's bad. They are always there and they are the lasts to give up.

> When Rolle (page 51) is in prison his mother spends that time in her country. When he is out of prison, she comes back to Sweden and they see each other daily until he goes back to prison. It has been like that for the last 10 years. Rolle and mother are very close and the therapist asks if it would be ok to invite her for a session. Rolle is a little hesitant and wants to make sure it won't be difficult for her. The therapist asks how Rolle would react should he accidentally wrong her and Rolle looks him straight in the eyes and says: "I would kill you."

Rolle was the only addict in the heroin program where we decided we wouldn't invite the parents. The team and the therapist deemed the risks for the therapist to be to high.

Parents as resource

Addict's problems are sometimes conceived of as caused by their parents. Maybe the parents haven't given the tenderness, closeness or care they should have given when the child was small, or they may have beaten, abused or done other bad things to the child without ever taking responsibility for it. When therapists sees parents in this way it is difficult to see them as resources or as helpful for the treatment. You would rather not see them at all or at least you don't want to talk treatment with them.

In the heroin program in the middle of the 80's we were influenced by theories that, even if not blaming the parents directly, had the basic idea that the problem was related to the family not functioning well. Our job was to make the families function better and our theory said that the addicts would then stop doing drugs. This view led to us sometimes getting into conflict mostly with parents but also with the addicts.

Co-operation

It took us a long time and a lot of effort to work in a new way. One where we could co-operate with addicts and their parents on an equal level and with the understanding that for the addict, loyalty to his parents is more important than loyalty to the therapist – blood is thicker than therapy. For the addict it is immensely important that parents are rehabilitated

and acknowledged. Feeling proud of ones parents increases ones own sense of competence.

Seeing parents as experts on their child is however not all that easy. It is I as therapist, doctor, teacher, etc who is the expert and the one who knows something. It is difficult but necessary to void oneself of this notion. This doesn't mean that one renounces to ones knowledge, but means that one tries to encounter the addict and his parents with respect and understanding and doesn't dominate them with ones own theories and views. Don't forget that parents in their contact with persons in authority may have gotten the idea: "It's our fault. We did wrong before. We didn't succeed in raising him."

It is thus important to help addicts receive help from their parents and family. Solving problems together, changing situations for the better and writing new stories together containing successes is tremendously importance.

In praxis

The first session with the family can start in many different ways and in many different constellations. The rest of this chapter deals mostly with ideas on how to meet people you haven't met before. It can be a father, a sister or a friend. When you've done something similar to what we have been talking about before, it will be someone the client wanted to bring in, or has agreed to bring in because you or someone else in the network thought it useful if that person could participate in the rehabilitation-process.

You can assume that he or she who invited the person or persons in question, expect that you will meet these people the way he was met and with which he was satisfied. Otherwise he wouldn't have invited anyone.

With this in mind it is not difficult to bring new people into the work. Think about the original ideas (pages 20-32) and note particularly participation. If someone is invited it is because that person is important or can become so. That person needs to feel implicated in the process in one way or another, and needs to share the "earnings" of success.

As always there are many different ways and we will only try to give general ideas by trying to be precise in the description of what we do.

How to start the session

Introduce yourself and ask for names. Make sure you got them correctly. Consider that you yourself may be quite nervous in this situation and that it is easy to forget names. Also consider that most certainly the people who are there are more nervous than you are.

Many new persons? Note the names in your head or on paper in such a way that you can easily retrieve them. Only very experienced therapists can allow themselves to forget names of people in the room and they seldom do.

Ask the client if it's ok that you recount what you talked about in previous sessions. He will answer yes[15]. Tell shortly about strengths and resources that you've dug out in earlier sessions. A starting point can be the intervention you did in the previous session. End by

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[15] If a client answers no; ask the client himself to recount what you talked about. When the client stops talking, add: "And we understood that you are (a) very important people (person) in his life."

saying that you've understood that exactly those who are there are very important people in the clients life.

Developing fit

There are many ways to develop fit and create prerequisites for co-operation. They can be used by themselves or in a number of different combinations. Those we use most often are "What are people good at" – "How was he as a child" or – "Imagine that this will be useful conversation".

- ***What are people good at?***

What is the client good at?

Turn to new persons one by one and ask them what the client is good at.

What is this family member good at?

Then turn to the client and ask what that person is good at.

Deepen

Ask who else would have something to add and what this person believes he or she would say. Ask the client calmly, quietly and curiously if he sees himself like that. If there is strong disagreement only comment: "You see this differently. That is good."

Such comments are very useful when people disagree and seem to work well as long as they are only on the brink of starting to quarrel. When you communicate on this meta-level about disagreement, you don't side with anyone. In principle it is always best not to take a stand except where you have to from ethical, moral or child protection aspects.

Do not try to erase differences. Differences are very useful when you summarize sessions. For instance mother is very positive and will not believe anything bad about her son and she seems to think that everyone should do exactly as he wants. Father is suspicious towards his alleged progress and seems to think that he should be put away to get some real help for his problem. The difference between the parents could be conceived of as a problem but can be defined in the summary as an extraordinary resource in this network. "Mother stands for optimism and father stands for realism – and both are needed."

- ***What was he like as a child***

Another way to get a positive and supportive atmosphere in the room is to start the session by asking: "What was he like as a kid?" "Was he up to mischief?" "Was he kind-hearted, good, well-behaved?" "What was he good at then?" "What is he good at now?"

Ask the client if he remembers and agrees. Ask those present what others, not present, would add if they were present (grandparents etc).

- ***Imagine that this will be a useful conversation***

A third way we use to start family-sessions is to focus on what the session can lead to: "Imagine that this will be a useful conversation. What will we have talked about then?"

Another way to ask the same question is: "Imagine that you leave here today and you are satisfied. You think the session has been rewarding and fun. What will we have done here today?"

This type of questions will quickly inform you what the different people' present thinks are important issues. This will permit you and the family to quickly and in agreement pick issues that are relevant to the different family members.

The question can bring forth many different answers and reactions and it demands an experienced and skilled therapist.

Many people will misunderstand the question and answer what they think should be the result of treatment. The question then becomes a variant of the miracle question and you simply follow the client/family. You get directly to the goals of treatment.

Sometimes you don't get concrete answers or descriptions. You should then insist and show that you are set on co-operating. Sometimes families don't have any ideas at all and this is most often due to strong feelings of hopelessness and resignation. You can then focus on the difficulties they have had and how they coped despite everything (coping-questions).

You may also get quite overwhelming answers with unrealistic expectations like all problems will be solved etc. Joke about it; "it's good to aim at the moon, at least you risk ending in a tree-top". Than deal with it the same way you deal with unrealistic goals when you ask other future-oriented questions.

Sometimes different family members seem to have incompatible ideas. Ask more in detail about concrete examples, listen for how the ideas can be connected to each other. Deepen the descriptions of each person. Often it turns out that family members have more in common than not. Most often family members are prepared to compromise in what needs to be prioritized.

Regularly different ideas will develop that everyone thinks are okay. Make an agenda. You can then take the different points one by one or decide what is reasonable to achieve in today's session. Deal with the problems one by one and create descriptions of how one will know when that problem is solved or on its way to be solved.

Previous change

Start the next part of the session by saying something like, "When I met Nisse I understood that he was really very decided (was pretty decided/ was on his way to make a serious decision) to stop doing drugs/getting straigt/putting his life together (use the client's metaphors). What signs have you seen that this is happening (starting to happen)?"

If you feel brave ask: "What has become better?"

The worst that can happen is that they answer: "Nothing is better." You can then ask in a natural way: "Haven't you met lately?" and leave some doubt hanging in the room where the relatives may ask themselves what signs you may have seen that shows that he is starting to change his life.

It is not uncommon for mother or father to start telling that this is not the first time that he has tried to shape up[16], and this may be an excellent opportunity for you to find out how they saw when he was trying before.

"How did he do then?"

"How did he show that he had the will to change his life?"

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[16] Be careful here as one easily misunderstands parents in this situation. You may get the idea that the parents are trying to correct your view of the client and you may believe that they are telling you not to have to much hope as they have had that many times and they have been disappointed more than once, and you shouldn't believe that you can help him when they haven't succeeded.

"What did they see?"

"What was different?"

"What was different compared to periods when he was in the midst of abusing?"

As usually go for behavioral descriptions. It makes the rest easier.

"Are there any such signs now?"

"Which? What have they seen him do? /heard him say?"

Some families tell that it has *always* gone up and down. This time is no different from any other time when it was a little bit better. You hear them imply that it is only a question of time before things are back to bad again. Accept this to start with. Draw a sinus curve on a whiteboard, or in the air. Say: "So things are going up and down. What signs are there that this is an up-period?"

"How is he different in this phase?"

"What can become even better?"

"What could be done to help him get a little bit higher this time?"

"What can be helpful for it to stay up a little longer this time?"

Talk about last week and the few last days.

"Has there been any sign that he is trying?"

"What have they seen him do?"

"What have they heard him say?"

Talk to the client about the ways in which the family has been helpful in the past. Ask what they used to do that was supportive of the decision to get off drugs. Ask what they are doing that is helpful. Ask in what ways they are different to him when they now/then see that things are going a little better.

With a clear focus it is easy to get a flow in the session. Make efforts to remember what you asked for and listen carefully to the answers. Don't let go of a question before you have answer, if you are not absolutely sure that the question is impossible. Try putting the question in another way, and if that doesn't work, in a third way. Don't be afraid of thoughtful silence on your part or the family's. Consider that the more you seem to think carefully about what they are saying, following up on their answers and trying to understand what and how they think and mean, the more professional they think you are.

Potential difficulties and some hints

Why is he addicted?

Sometimes families and networks are very preoccupied with trying to find the reasons for the problem. You will notice it because they will tell you. Ask them about their explanations. They will answer or say it is completely incomprehensible. Listen respectfully. Ask what others may think but don't immerge yourself in the issue and leave it as fast as you can. Try saying: "We can't do anything about what has been."

"Right now it is not about working through the reasons but for him to get out of the hold that the drugs has on him." You can also try saying: "There are many theories about why people start doing drugs (drinking), and no one knows today. Me neither. We know less today about why one starts than how one stops."

Sometimes we have explained that there is not one or two reasons that can explain how it has become the way it is. Hundreds or thousands of different things interact and one can spend a lifetime trying to sort out the most important. Right now the most important thing is for him to stop abusing and then Nils can sort it out afterwards if he is still interested.

Sometimes we have said: "We have to put the fire out before finding out why it started."

Mother and father are very angry

Some parents will immerse themselves into all the evil the client did. Try responding in a supporting way but make a distinction between the problem and the person: "The drugs really made him do terrible things."

Many are angry and irritated

Stay calm. Slow down the pace of the session if it's fast or if the atmosphere is tense. With a tense atmosphere it is particularly important to block aggressive interaction between family members.

> The therapist (PA[17]) spends most of the session sitting on the table between Britts' mother and sister. Every time they start talking they start arguing with each other. Every time he rises and lifts his hands with his palms towards them and says: "Stop, wait a second." Every time they fall silent. Every time he tries to return to his chair they start arguing again.

It's of no use to the client that mother and father is arguing with each other, or that a sibling accuses the parents that it is their behavior that has caused the problem. Nor is it of any use to the client to accuse his parents that it is their fault that he is drinking, putting a needle in his arm or bingeing.

Other addicts in the family

Pay no attention to or at least don't immerse yourself into other family member's eventual drinking problem or other. This will only constitute another possible explanation for the problem, and you don't have to know why Nils is doing drugs. Even addicted parents can help their children stop, and some of them will stop their abuse in the process of doing it. Observe that it is frequent for young people to seek treatment when their parents just stopped abusing. If this comes forth, accept it, and congratulate the person on his success.

Desperation and exhaustion

Are you meeting only desperation, exhaustion and anger towards the client? Think of the fact that them being there contradicts anything implying they don't want to help. Their way of expressing themselves is proof of their enormous involvement. Try coping-questions (page 43).

The goal

When you've gotten this far in the interview, you will have a pretty clear picture of what family members hope for in the future. You may even have a few concrete, behavioral goals that you and the family can use to measure success.

Make sure you have enough of that kind of information by asking them how they will notice when things are going a little bit better. Don't be afraid to examine or point to differences between different goals. Stay calm in front of these differences. Remember that it is usually easy to connect seemingly different goals or help people see that they are

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[17] Peter Appel, The Heroin Program

dependent or complementary on each other. This is true even if they seem contradictory at first sight.

Sometimes it can be a relief for parents of young people not that interested in stopping drugs, if you calmly and matter-of-factly inform them that you actually never met an addict who didn't desire the positive effects of drugs. Addicts actually don't want to stop using, they just don't want to have the side effects of the drugs.

> Björn sighs with relief when the therapist has said this, looks at his mother and says: "I told her the other day that actually I don't want to quit."
>
> The therapist looks at mother, sees that she looks very concerned and comments: "That's a good sign, him daring to be so honest with you now".
>
> She nods and smiles and the therapist adds, "Him telling you now must mean that he somehow knows how impossible it is to have only the positive effects."
>
> Björn nods in confirmation and the therapist sees how mother and son look at each other in mutual understanding.

Are the changes so forth in the direction of the goal?

This is probably one of the most effective strategies existing for anchoring change, as it makes people feel they achieved it by themselves.

It is necessary that you and the family made descriptions of one or several unusual aspects/news in the present situation, or that there were descriptions of new behaviors. If you think that you can ask the question: "Is it as if a piece of the miracle already happened?" and get an affirmative answer; do it. Follow up with, "How did you do it?" or "How did you dare?" to the one responsible for the new behavior.

Examples are for instance a divorced father who invited his heroin addicted son to a fishing trip two weeks earlier, or a wife flushing liquor out for the first time, or an alcoholic stopping a period on the fourth day instead of the seventh. Does the person seem to be offended by you asking about things that should be evident? Explain that you don't see these behaviors as simple, considering that it is not easy to forgive someone who caused a lot of hurt, or do something one hasn't done in a long time.

Every example where someone can be held accountable for change should be commented. The merit of this change can then be shared through questions about what, who and how the support came from for that change to take place. These are questions that tend to connect people around functional behavioral patterns and make them confident in their own competence. This increases both their self-confidence and their trust in each other.

It is quite common that people don't know how or what they did, when they did something good. We often comment this with: "So it's a mystery how you did it when you succeeded?" When this question is asked with curiosity and amazement, it often leads to an affirmative nod. As mysteries exist to be solved there is always the chance, after an interview with one or several mysteries, that the client and family continue to think about what and how they did something that worked.

The next step

"So what is the next step?" or "What do you plan?" If you are in an early stage and there are no signs that things are going better, an alternative may be: "What do you have to

do/ what will you do?" Observe that this question should be put to the client and not to the family. The family is not responsible for their child's drug-use. If you ask for the family to do something different – the question contains an implicit demand – you are also saying that it is their responsibility to change the situation. It is worthwhile thinking that it is mostly pointless to try and force people to change, and that you're probably trying to do the same thing to the family as they are trying to do with their addicted child, and with as little result. Do you feel an urge to foster them and tell them what to do? Lean back and tell yourself that you are working to hard and that you are not listening enough to how the family wants to deal with the issues.

Usually family members and the client have ideas on what should be the next step. Help them to be concrete in small measurable steps. Define these as small, small parts of the miracle. This will help them all to see change and development.

You should accept that the client is not off drugs in the first session with the family, particularly if it is the first week of treatment. It is good if you put some pressure on him at this stage, in front of people that are emotionally important, but it's not useful if he "looses face". Consider that addicts also do their best and have strong reasons to do what they do. Are you a cautious person? Then ask: "What's your ideas on what you need to do to take the first/next step?"

Follow up with: "In what ways can mother, father, sister, brother etc. be of help?"

No answer? Well, turn to the family and ask them for their ideas on what the client needs to do. Don't expect to much if you get into this situation. The family can lead their child to the water, but they can not force the child to drink. In this situation you will probably get answers turning around "he must want it himself", or "he must get into some treatment program". Try listening for ideas about how they would notice that there was any "will" or any metaphor they choose to use. Ask more about how they will notice (or suspect) that treatment has had any effect, and explore if anyone has any idea about how they can make the client want to "get into treatment".

If you get the feeling that no one wants to do anything to try solving the problem you probably missed something important. It is not likely that the client agreed to invite other people if he doesn't want to change anything. Maybe something important or serious happened in the interval since the family was invited. Try to get hold of the situation as it was before an eventual relapse yesterday or the day before, or any other crisis that might have occurred. Talk about what needs to be done to at least get back to the same point as when the client agreed the family should be invited. In this situation you probably already know or at least have a strong hunch what it's all about.

Even in situations where the family seems to want to talk about all the problems and seems to need to talk about how terrible everything is, it is possible to get to the next or first step. Get hold of the concrete situations the family is talking about and explore how that particular situation would have developed differently after the miracle. "How will a similar situation develop differently after the miracle?" or "What would that particular situation had looked like if there was no problem?"

Scaling questions

In a slow pace and with 3-4 people in the room it can have taken you anything between 30 and 60 minutes to get this far. The longer you spent, the more you are in a hurry now.

If you haven't asked scaling-questions before, you can do it now. Useful ones at this stage can be: "On a scale from 1 to 10, where 10 stands for; you're certain Nisse will stop

using drugs, and 0 stands for no chance at all, where are you?" To the client: "Where do you place yourself?"

"On a scale from 1 to 10 where 10 means that you are prepared to do just about anything to solve this problem, and 1 means the contrary (just sitting on your but waiting for a miracle?)"

"Confidence in your/his ability to go one week, or two weeks without drugs (or whatever you think is a reasonable time span before the next session)?"

"Confidence in ability to wake by the alarm and go look for a job?"

Ending the interview

For the moment be satisfied with what you've got. Explain that you talked about some things, of course not everything, and that you now need some time to think through what you talked about and summarize how you understand the situation, and also see if you have some idea that you think can be useful. Explain that you usually take a break at this stage to discuss with your team (with yourself) and then you will be back with what you think. You can very well ask them if there is anything important they think you should know, or if they can think of a question that you should have asked and they think you missed. Then ask them to step out to the waiting room, or leave the room yourself. Reflect for a while with paper and pen to sum up, and then tell the family how you see their situation. The summing up of a family session contains the same elements as the summing up of any other session (pages 44 - 48).

Example

The parents are the experts on their child

The prerequisites for the sixth session with Kajsa could have been better: The therapeutic team thought that Kajsa had been a little to long in the treatment-institution before we had succeeded to set up a meeting with the parents and the contact-persons in the institution.

The contact-persons and Kajsa are in massive conflict, and Kajsa has difficulties sitting in the room with them. The situation in the unit is becoming untenable because of Kajsa's behavior. The contact-persons wants to discuss this with her to help her change her behavior, and avoid having to discharge her from the unit. Kajsa doesn't see the situation in the same way – she seems offended, questioned and humiliated. She is angry and sulky – and she intends to discharge herself from the institution. The parents don't know what happened and seem surprised facing the very tense situation.

In the session are Kajsa, her parents and two contact-persons from the unit.

The therapist (SE[18]) introduces the context: "We have asked you to come here because we need to co-ordinate what we are doing and find a common goal in order to help Kajsa moving on." She then asks how the situation is (at this point she is not aware of the conflict between Kajsa and the contact-persons). The contact-persons recount briefly what has happened and wants to continue to sort it out with Kajsa. She doesn't want this and the tension increases in the room. Suddenly she rises and rushes out of the room.

[18] Sonja Edvardson, The heroin-program.

"Now she behaves as if she was three years old again", says one of the contact-persons in a worn out voice.

Mother goes out after Kajsa but returns after only a few moments, shakes her head and says: "When she's like that it's best to leave her alone. It's no use talking to her now."

"What else helps? How can the personnel know when she is like three years old and what's the best way to deal with her then from your experience? What have you found that is most helpful?" the therapist wonders, and mother describes in detail her experiences in meeting Kajsa when she is angry.

The therapist steers forcefully for the remainder of the session. When the contact-persons describes Kajsa and how and what she did, the therapist systematically turns to the parents and asks if they have seen such behaviors before and the best way to deal with it. The parents, as natural experts on their child, take on the role of consultants to the contact-persons.

The contact-persons describe the conflict in the ward: "Kajsa was so mad I thought she would hit me, but then she turned on her heel and left".

"Yes," says mother, "that is what she usually does". She turns towards father and asks: "Wasn't that when she phoned you?"

"Yes" answers father, "she phoned and said they treated her like ...." he pauses briefly, then goes on: "..... bad and she was going to sign herself out. I told her she should think carefully about it in order not to make a mess for her, and then I talked to you," he says while turning towards his wife, "and you phoned the housemother."

The contact-persons now recounts that Kajsa talked to her father and then went to her room where she didn't want to talk to anyone. Eventually the housemother spoke to her and said the same thing father had said; take it easy, think about it, stay here and sort it out, think ahead.

Everyone agrees that without this joint attitude from parents and staff, Kajsa wouldn't have stayed. Everyone also agrees that the situation in itself is a sign of Kajsa's progress, as it is the first time in many years that she didn't run away from a conflict but stayed and wanted to sort it out.

What would have happened if the therapist had tried to sort the conflict out by helping everyone to tell their version of what happened? Most probably the conflict would have increased. So what did the therapist do? When we look at the videotape we see that SE is doing only one thing: Again and again and no matter the issue SE turns to the parents and asks for advice and information. She treats the parents as the experts on their child, and conducts the conversation in such a way that the team and contact-persons asks and listens to them.

She also helps the contact-persons use the parents as a resource in treatment.

Sonja turns to the staff and asks: "What can the parents do to support the treatment in your unit when Kajsa calls them and complains about you?"

The personnel answer the therapist. Mother listens attentively and nods thoughtfully when they say that the best is if mother doesn't say to much before she has talked to the persons Kajsa is complaining about. She wonders: "Can I call immediately?" and they answer that; "that is exactly what we hope for".

The session is ended with a short conversation with Kajsa, who has been waiting outside. SE presents different options for the next session; joining in the session, following the session behind the one-way screen or not coming at all. In the summary of the session co-operation is emphasized, particularly important with such a special and different addict as Kajsa. In the next session one week later Kajsa attends.

When a therapist has the idea that it is the parents that caused the problem it is practically impossible for him to ask them for advice or encounter them as experts. Instead the therapist will tend to take over, trying to do what the parents failed to do; foster the

child. Clients are usually not very fond of this – as others they need to be proud of their parents, and see that their parents are treated with respect.

Talking isn't enough

In the session the family, Bengt and the therapist (ASH[19]) have discussed what Bengt needs to do to take the next step in his rehabilitation. Bengt has been off drugs for some time and has started to orient towards a life with work and without drugs.

At this point everyone agrees that Bengt has to take some concrete steps and it is crystal-clear for everyone what he needs to do. It isn't that clear that he is prepared to take these steps just now – Bengt seems hesitant.

During the summary the therapist asks the family if they want to have the next session before or after the next step Bengt takes in his rehabilitation.

They immediately answer "After the next step".

Bengt mutters: "It's not that simple", but someone immediately retorts:

"You just got to do it!"

Everyone agrees that Bengt has to do something of what constitutes the next step, not just talk about it.

The last question and the family's response to it clearly clarify the client's responsibility for his rehabilitation. It's concrete action that counts. The most important people around Bengt all have a positive expectation on him that he can't come around through his usual maneuvering.

Before the next session, Bengt had done what had been discussed in the session.

[19] Aviva Suskin-Holmkvist, The heroin-program.

MEETING WITH THE PROFESSIONAL NETWORK

The professionals are professionals

Who is part of the social network?

By *social network* we mean everyone who is involved in the clients life. Parents, siblings, husbands, wives, children and grandchildren, colleagues and employers, relatives and friends, social workers, probation-officers etc.

With *professional* network we mean the people who are involved in the clients life on a professional basis. When the client doesn't need them anymore they will withdraw and devote their time and energy to other people that need their help.

It's not uncommon for a social worker to be one of the most important persons in the life of an elderly alcoholic and sometimes the probation officer can be one of very few "normal" people in a criminal addict's life. For psychotic addicts the most important social contact can well be staff in a day-care-center or in a mental-health-institution.

Collaboration – co-operation

Important people ought to participate in the process of change. We humans see ourselves as we think others see us. When other people describe that we did something good, this description can make the difference it takes for us to see it as something we did ourselves and therefor owns. When families can't participate in therapy for one reason or another it can therefor be worth while to examine if someone from the professional network can participate instead. Of course it is best if this someone has known the client for a long time. Changes such a person observes will have greater credibility for the client than observations coming from a person who only knew the client for a short time.

Sometimes clients come alone or accompanied by family members to the first session. Co-operation with the professional network will be needed only if you (the family, the client and lastly you) think that treatment isn't developing the way it should, or if the family thinks that they and the professionals are pulling in different directions. It may be productive to see differences of this sort as an expression of the fact that clients tell different things to the professionals and the family, as a result of these people asking for different things. Clarifying this in a meeting with the people involved is often enough to avoid a potentially destructive development. Such a development may for instance be the client being seen as manipulative.

When life is developing in the "right" direction there is no need for the professionals to meet. Most helpers are perfectly happy when things go well for their clients and are

grateful when they can stop working on a case. They don't have to come to your sessions for this to become clear. Most often it is enough that the client informs them that their help is no longer needed.

In the out-patient-contexts where we work, a professional (the referrer) frequently accompanies the client to the first session. We know that it is not so in most other contexts, but we want to recommend it.

Social workers and probation officers are good at making clients come to therapy. As many clients don't have much hope that treatment can be of any use to them, they often do not come entirely out of their own free will. Usually the referring agent contacts us and we discuss if he or she can bring the client in for the first session. We explain that the chances of the client showing up increases dramatically when someone who has known him for a while comes along, or even picks him up before the session and drives him to us.

In these sessions it is useful for the people involved to clarify who is responsible for what and decide how the contact with the referring agent is to look like. Is the referrer to participate in all sessions, or in some? How will the referring agent be informed about the result or no-result of treatment? What about the contact between the client and the referring agent?

Why co-operate?

Frequently family members and particularly parents, think that "alone is strong" or "we got what we deserved". Out of consideration for other family members and for the addict people sometimes hold back important information to other people who are concerned and who care: "He has so much at work right now". "I can't put more weight on her with this trouble." "If I tell him this, he'll get a heart-attack, anxiety-attack, kill himself or kill the boy."

It is also common that one doesn't want to involve others: "We deal with our own problems." "One should be able to deal with problems without involvement from the outside." Or: "We won't get any help anyway; they'll say that it is our own fault, that we did something wrong, that we failed to raise him properly."

Participating in treatment with the professionals can therefor be a very important experience for family members.

Another reason for meeting is that in the ensuing conservation one helps each other clarify different roles. Family members and professionals have different roles and functions and contribute with different things. By meeting, talking and listening, one supports each other and, above all, shares new perspectives with the client and the family members.

Differences in the encounter with professionals compared to the family

There are differences in how you meet professionals compared to how you meet family members. When you see families you point out how they are helping their family member towards a life without drugs, and in particular you are emphasizing their emotional support.

When meeting the professionals you emphasize more how the professionals are or have been supportive and/or coercive in a way that is helpful to the client and you avoid emotional overtones.

Phrase your questions so they fit the relationship you are asking about, and with increasing skill you can also use your questions to clarify who is responsible for what.

You ask the client: "What does your father need to see to be proud of you?"

A question in the same vein to the social worker will be: "What do you as a social-worker have to see to leave Nils alone?" or you ask Nils: "What does your social worker have to see to think you are doing all right?"

You ask the employer: "What does Nils have to do so you can let him keep his job?"

Different inceptions – different situations

Desire for co-operation and collaboration is most often expressed by someone in the professional network, or by a family member other than the client.

Occasionally a wish to collaborate is expressed by a client himself. Most often these clients either have a particular wish (wants a special treatment, wants to go to a particular institution, etc) or feel they need a stable structure with clear limits to stop their problematic behavior.

Make sure the client, the family or the professional network expressed a purpose with the meeting. (This can include a purpose expressed by you, but it is always wise to avoid becoming ones own customer). Of course the expressed purpose may be one of many, but if someone has been clear with what they hope to achieve it makes things easier for everyone.

In what follows we sketch a few situations where the client, the family or the professional network may confirm that they want to meet with other people in the network.

None of these situations is ever pure in the every day world of practical clinical reality, and they can always be defined in some other way. We have arranged them in the following order; wishes expressed by the clients come first, than the families and lastly the professionals. We feel that this is the prioritizing that is best to use when we decide to ask questions that may lead to someone expressing that they need to meet other people in the network.

Collaborating - the addict's view-point

When we try to help clients feel that they have some control over their life, we want to help them experience that it is they themselves who decide something of their future. It is then important that we use our privilege to ask questions in such a way that the client feels that it is what he thinks that determines what the co-operation with the professional network is to look like.

The alibi situation

A situation that is not uncommon is that clients come to therapy because a social worker or probation officer thinks the client needs treatment. If the client doesn't want to go into treatment the children will be taken away from the home, the welfare money will not be paid, or the client will have to go back to prison. Your treatment (or any treatment) then becomes the client's alibi, and "getting treatment" is more important than the content of treatment.

One usually notices very quickly when a client is in this dilemma, even if some clients won't tell you spontaneously. Sometimes the referring agent has informed you about the

situation, but many professionals don't feel that they are "forcing" the client into treatment. They feel that they have been straight and fair and clear about how they see the client's situation. They made it clear to the client that they think he needs treatment and; "he agreed".

Frequently the client expresses that he has no problem and he is moderately (or not at all) interested in the conversation. When asked the miracle question or other future oriented questions the answer may be that the social worker would leave him alone and then there would be no problem. It quickly becomes clear that the client is in a situation where an authority is expecting something from him, and he doesn't agree with the authority about the goal or is not clear about what it is. Useful questions can be:

"What do you think N.N. hopes you can get out of coming here?"

"What do you think N.N. needs to see you do/you can handle/ happen in your life, for him to leave you alone afterwards?"

"When good things happen in your life, how will N.N. notice that they have happened? What will you notice on N.N. when you talk to him, after he has noticed the difference?"

Notice that as usually the form of the question is not *if*, but *when*.

"What do you think about us asking N.N. to join us next time we meet, so we can find out what he hopes for you to get out of coming here?"

"On a scale where 10 stands for N.N's involvement in your life being a huge problem, and 0 stands for the opposite, where are you at today?"

We want to emphasize that this is not necessarily a bad situation. We don't see coercion as an impediment to treatment. At times it seems as if coercion and firm demands from a relatively non-understanding environment, is something that clients can experience as something that helps them get a direction in their life. A social worker can with his presence and a realistic list with demands, bring about considerable improvement in the life of a client and his family.

To some extent it will depend on how much hold the professionals have on the client. A good many clients are often very interested in *not* going into treatment - at least not because someone else told them to - and can look very seriously into what they have to do so they won't have to come anymore. With these cases we inquire carefully with the client and the 'referrer' what needs to happen for the addict to be 'off the hook'. In this way it will be apparent for everyone involved why the client has come and what is expected of him.

So called 'unmotivated clients' are often surprisingly co-operative when it comes to what they need to do, in order not to be forced to do something else. By accident it may even happen that they do something that is good for them in the process.

It is advantageous if the person who 'forced' the client to come is present. It is both easier to talk openly and get realistic goals that can build both on what the professional thinks the client needs to do and on what the client wants to change. It is sometimes surprising both for the referring persons and us how much 'insight' these clients have in their situation.

The professional-can-add-something

Addicts sometimes get into the situation of having improved their life so much that they are able to use the help authorities can provide. The problem is that the concerned persons in authority, knows your client as someone who has exploited them, broken contracts, not

kept promises, or a number of other things that has led to the persons in authority no longer wanting to, or being permitted to help (by their bosses).

It will not always be easy to get these persons in authority to join in meetings with the client/family, as they have decided that they can not be of help.

> Jonte has gambled for many years and has huge debts. He has nice manners, good academic training in computer- and office-work, and is generally a very nice person. The problem is that he has the habit of quitting jobs after a while, by simply failing to show up. Jonte blames this on his gambling problem and staff at the employment agency have decided that he is "not capable of holding a job" before he is "cured". In sessions with HK, Jonte thinks that he can neither be – nor know if he is – "cured" before he gets a job and he feels he is in a catch-22-situation in relation to the employment agency.
>
> At a meeting with the professional network the employment agency agent clarifies what he needs to see to start believing that it is possible for Jonte to keep a job. Jonte has to handle no matter what job for three months, and after this time he will receive appropriate help from the agency.
>
> After this session Jonte stops therapy with HK. He finds a cleaning-job, keeps it for three months, and then resigns. He then contacts the employment agency and demands that they fulfill their promise, which they do.

A similar situation can arise when you are interested in helping an addict come to a special institution of his own choice.

In the future it will probably become[20] more and more difficult to make placements in institutions based on client's own wishes. Making this clear to clients, and making it clear that social authorities are prepared to pay only for inexpensive out-patient treatments can be one of the purposes of network meetings.

Collaboration - the families view-point

A need to collaborate with others arises in families who think their own effort is inadequate or doesn't yield enough result.

The treatment shows no result / The family is dissatisfied

> Magnus' mother is involved, interested and does what she can. Magnus is having a very difficult time. He uses so much drugs and alcohol that he gets new bruises every day, and two to three times a week he ends up in the hospital. Magnus' mother rightly thinks that not enough things are happening in the right direction.
>
> "Can't anyone help me with this? He'll kill himself and I'll blame myself for the rest of my life for not having done enough."
>
> Magnus has stopped coming to sessions, but mother has continued on her own. The social workers are not aware of the seriousness of Magnus situation.
>
> "It's insane what he is doing. Can't he be put away for a while so he gets a chance to pull himself together and not kill himself?" she asks. We answer: "Do you think it would be a good idea if we invited his social worker here to inform him about how you see Magnus situation, and to hear what they have to offer?"

For the family, the purpose of meeting in this and similar situations can be that they want the authorities to act forcefully to stop the abuse. Sometimes the purpose of situations, more or less clearly related, can be defined as a need for clarification.

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[20] Speculated in the spring of 1993.

Mother and father have stopped giving money to the addict and are angry because welfare is continuing to pay money that is used for drugs and alcohol.

The client/family in in conflict with the authority

How a situation is defined has great importance for how it is handled. Conflict and disagreement doesn't always have to be addressed directly.

Anton, 35 years old, moderately developmentally retarded, has lived for many years in an institution. In therapy with his family he develops an interest in sports, and starts socializing with members of the local fan-club. He makes rapid progress and stops smoking hashish and drinking alcohol. His older sister in particular insists that he should get an apartment of his own, learn to take care of his economy, and become more independent towards the institution. She helps him get an apartment and the institution is faced with a development they didn't plan and are not entirely positive about. In family sessions the sister in particular describes how the staff is doing their best to sabotage her trying to help Anton become more independent. The sister, the mother and probably Anton are all worried that the staff may withdraw their support, which most probably would lead to Anton failing to mend for himself and would force him back into the institution.

In the meeting defined as ”a meeting to discuss and reach an agreement so that everyone pulls in the same direction”, Anton’s present situation is described as a result of great progress, and everyone present is ”blamed” for this progress. The therapist makes it credible that the staff has ”laid the foundation” and the sister has helped with the ”final steps” towards independence. Everyone expresses that they are concerned and wants to help Anton towards even more independence, and the staff clearly expresses that they intend to continue working with Anton. The sisters impression of the staff working against what she feels is Anton’s best interest, is never brought up.

When the meeting is over, everyone seems happy, contented and proud. Everyone leaves with what seems to be optimism with regard to Anton’s future.

Many involved

Our experience is that many clients have many professional helpers involved in their life, and they can handle it too. For parents and professionals, it can be quite overwhelming and confusing though. A wish to coordinate the efforts is sometimes expressed by the clients, though more often by their parents. This coordination however is frequently most needed by the professional network.

Collaboration - the professionals view-point

When many professionals are involved in a client, a wish for collaboration often arises. The purpose of these meetings is mostly to inform each other about what is being done so that the efforts can be coordinated. To avoid hidden agendas it is almost always wise if the clients and families are present at these meetings. This is particularly true if anyone suggests they shouldn’t.

Professionals participate in meetings for different reasons. This means that a meeting can develop very differently, depending on the setting, the participants and the goal.

- Professionals express a wish for a joint attitude and direction.
- Professionals need to discuss and solve conflicts in the network.

For most of our clients it is not a big problem when different professionals have different opinions. They adjust easily. They talk to their social worker about money, they talk to their therapist about how they feel, and they talk to their probation officer about

drugs and crime. On a general level this is not a problem for anyone, unless the different perspectives (and maybe directions) collide and conflicts arise, or if the clients gets confused (which sometimes happens).

One useful principle for these meetings is that ”ideas are more important than people”. The important is what is said, not who said it. Professionals and family members all have good and useful ideas, but it is seldom possible to carry all of them through at the same time. Conflicts easily arise when one has to choose.

It is important that the therapist focuses on how the meeting can lead to something constructive. The therapist’s job is to lead the discussion into future possibilities – not looking for faults in the past. With angry and upset people this may be difficult, and the session should be led in such a way that the risk of eruptions is minimized. Focusing on how each person wants things to become, and how each one can contribute to a solution, increases the chances of a constructive conversation and cooperation developing (see for instance Valeria page 81).

Initiating the meeting

Best is if the meeting is initiated from desires or wishes the expressed by the family. Second best is if the meeting is initiated from the professional network and third best is if it is the therapist who summoned the meeting. It is wise to give some thought as to who is the customer, and you should be careful so you don’t become your own (and perhaps the only). Meetings initiated from desires or wishes expressed by therapists tend to lead nowhere.

Calling the meeting

Best is if the client calls for the meeting himself. Particularly if he never did anything similar before, this situation can be used in a way that enhances growth. Work through concretely *who* needs to come, *what* he needs to do and *how* he can make the people come that could be of help to him.

”Who do you think can be of help to you?”

”Do you think the easiest way to get them in, is you calling them or is it better to write them a letter?”

Some people find it very humiliating to ask for help. They tend to believe that ‘alone is strong’, and they are often governed by ‘cowboy-mentality’. It’s no use trying to persuade them. Instead point out to them that the ability to ask for help when one needs it, is a sign of real maturity[21]. You can often get these clients to agree to a meeting but it may be to much to ask that they should do the inviting too. Volunteer to be the one calling to invite the network.

Scrutinize carefully who can be of help. Merely discussing and thinking about who can be of help leads to thoughts that have to do with solutions and positive development.

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[21] Minuchin calls this ‘universal thruths’. When expressed with authority and as something very obvious it may lead to a shift in attitude.

Starting the meeting

Introduce yourself and ask about the names of the people present. Ask each one where they work, their professional role and for how long they have known the client. Be as respectful if it's been ten years once a week, or one week since their first and only meeting with the client.

If many people are present, nametags can be useful and even fun while people fill them out.

It is important that it is clearly said where everyone comes from so that everyone knows that everyone else got their role and position correctly. It can be very unpleasant for an old social worker to be perceived as the clients mother, and it may even be offending. Even if you personally don't have any problems with personal and professional roles, many people are not that lucky. Make it easy on them. Those who don't have any difficulties with this won't be offended by it being clearly said that they are there as professional helpers. It is your job to see to that everyone goes home without loosing self-esteem or face.

Talk to everyone about how long they have known the client or known about the situation. Pay close attention if someone starts talking about things having gotten better, but save it until you've clarified the purpose of the meeting.

Clarify the purpose

Every situation can be described and defined in many different ways. When you decided the purpose for a meeting, you also took a stand towards, and described a situation. Reflect in advance on what kind of descriptions can be made and how they can be useful.

Clarify who has taken the initiative and called for the meeting and why. Remind those who are there, and yourself, about the overall purpose, by expressing that everyone is there because they want to do something that can help the client do something to change his situation.

”Nisse has tried for a long time to stop doing drugs and on previous occasions he has been helped by ... What ideas do we have here today that we think could be useful for him?”

”Nisse and his parents don't see the kind of progress they were hoping for and wanted us to meet and discuss together what can be done.”

”We are a lot of people here who are involved in Nisse and wants to help. The social-worker thought it would be a good idea if we all got together and figured out how to proceed from here.”

Set up goals for the meeting

One of the best ways to initiate a meeting is to make some kind of agenda based on the idea: ”Imagine that this will be a useful meeting and everyone is satisfied afterwards. What will we have done here today?”

Another way is to start with: ”Imagine we meet here in three years time and Nisse is doing fine. How do you think that happened? What do you think Nisse did? What do you think we did that was helpful?

A third variant is that everyone is given the opportunity to discuss what they think is important and depending on what is said and the time available, an agenda is done for the meeting.

A fourth way is that the person responsible for the meeting asks everyone, one by one, what he or she thinks the client will have gotten from the meeting if it will be a useful one.

All these ways to initiate meetings aim at creating descriptions of goals. It is amazingly easy to create an atmosphere of hopefulness and belief in the future, but the therapist needs to be active and goal-oriented in order for this to happen.

Deepening (enhancing)

The deepening part of these sessions will be very similar to family sessions with one big difference. Questions around closeness/ distance and emotions are avoided. Apart from this, follow the plan we proposed for the first session with the family. Give the network, particularly those who have known the client for some time, the opportunity to talk about the changes they have seen or see now. Alternatively talk about the steps the client or someone else in the network is planning.

How the rest of the meeting will develop largely depends on how and why it came about in the first place. Isn't treatment making any difference and are people pulling in different directions? Will there be a difference if everyone starts pulling in the same direction – and what direction?

Is this a situation with a sparse network around an isolated schizophrenic who is drinking himself to death and where one may have to commit the client against his will or is the purpose of the meeting to help the client get started in a day-care-unit?

Many other factors are of course important, for instance; how many people are present and if there have been conflicts in the network.

When we coordinate meetings with more than 10 people it is impossible to ask each one for every detail. We then divide people into groups to work on different issues and bring their work back into the main group.

The ending

The goal is for the meeting to be closed in such a way that everyone feels satisfied. Loose ends, unanswered questions and other unfinished business should not be left hanging in the air.

When the purpose of the meeting was that people should get answers to a number of questions, one can finish the meeting by asking each person to sum up if and how their questions were answered.

When the purpose of the meeting was to make a common action-plan for how to be of help, one can repeat together what the plan is, eventually write it down and give each one a copy.

When the purpose was to sort out conflicts, one can finish with a short discussion about how far one got.

Other ways we've found useful are:

- The therapist writes a protocol, which is distributed, to the persons present. The protocol can also be sent to persons who were unable to attend the meeting.

- The therapists takes a break, sums up the meeting in the same form as after a conversation with a client or a family, and then reads the summary to everyone present.

Two examples

The co-operation that never really started

Kim is 14 years old and feels uncomfortable at home with her parents and her 2 siblings. Her temper leads to violent conflicts, particularly with her mother. She comes home later and later, and when her parents question her she gets into rages and throws things. She goes to school every day, but skips classes and the teachers don't know what she is up to. One day she is involved in a fight and after this she disappears from school. She returns the day after, running around with a penknife looking for the adversary from the day before. The police arrive and in the afternoon the same day the whole family ends up in child psychiatry.

When the therapist (MS) comes into the room where the family is sitting, Kim looks at him defiantly, turns her chair so she has her back against everyone else and pulls her sweater up over her head. During the course of the conversation her many positive sides are highlighted, but the therapist doesn't succeed in establishing any contact with her.

The therapists sees Kim in another session and her parents twice and the parents report having dealt with some difficult situations in a new way and also some progress with Kim's behavior. Kim says to her parents that she stopped smoking hashish but as there is very little progress in school, the parents don't believe her.

More and more people around Kim get involved, social worker, school-nurse, teachers, friends, her friends parents, some relatives and friends of the family. The parents receive a lot of different ideas from different people and the therapist starts worrying that they may become confused by all the good advice they are getting, sometimes contradictory. He suggests to the parents that a meeting with the network could be useful to find a way to deal with Kim and her situation. At about the same time the social worker becomes increasingly worried. She gets telephone-calls from the school, urging her to do something about the situation. She starts considering putting Kim in an institution for delinquent children.

The therapist and the social worker meet once. For the rest the collaboration in the professional network is done over the telephone.

The meeting never takes place. Kim is eventually taken by the authorities and placed in an institution.

Why was there no meeting?
There are no definite answers, but what do the people involved say?

The parents:

"First we thought it was a good idea, but then when there couldn't be any meeting before the 'Social' had made their decision, it sort of became to late. The meeting would then only be some kind of parenthesis. When we started thinking about who we wanted to invite, there were quite some people – but what if no one would come and we would sit there all by ourselves. Besides everyone knew about the problems."

The social-worker:

"I thought that at least the most important people could attend a meeting, if it was to difficult for the parents that everyone was there. On the other hand the situation was so critical that we had to make a decision and act – that had to be prioritized."

Previous therapist (whom the parents consulted):

"I believe an institution is the best for Kim."

The therapist:

”The idea about a network-meeting was mine from the start, but I didn’t succeed in making the purpose of the meeting clear to the people involved. I could see a scenario where no one could reach Kim, everyone would continue to give the parents good ideas and they would become more and more confused. The purpose as I saw it, would have been to coordinate all the efforts and in some way make sure the parents were running the ship.

I can understand that parents and professionals don’t always want to have large meetings where there is a big risk that one feels exposed and looses face. I didn’t see the taking her into custody as a hindrance for the network meeting – on the contrary. I think it would have been a good idea to gather everyone who cared about Kim to talk about the seriousness of the situation and discuss how to help Kim avoid being taken into custody, or eventually making the stay in an institution something helpful.”

Valeria

Valeria is slightly developmentally retarded and the kindergarten has asked for a meeting with her social worker who in turn asked the therapist (HK) to participate. The social worker has been concerned about the children’s situation and has tried to help Valeria so the children could stay with her. Valeria has seen the therapist three times, and her goal has been to find more effective limit setting towards her 5-year-old daughter.

It is the administrator who opens the meeting and she does so by turning to Valeria. She explains that her staff is very worried about the children. They don’t seem to feel well. She continues: ”It is important that you understand that we want to help you.” Valeria looks at her with a numb look on her face, and the administrators voice turns a little strained. ”It is difficult in the mornings when you leave the children and you stand here talking to the staff and you forget the children, but you must understand that we are here to help you. You forget the children, and the children are sad when you are leaving, and it goes on and on, and we see how badly Johanna feels and also the small one.”

The administrator takes a brief pause, fidgeting in face of Valeria’s dumb staring. One of the staff goes on describing the difficult interplay when Valeria leave and pick her children up, and how bad the children feel about it all and how sad they are. She also turns towards Valeria, who is now crying and holding on as in a cramp to her 8-month old, sitting on her lap. Another one of the staff takes on, telling her they want to help, and that actually Valeria smelled of alcohol once in the afternoon when she came to pick up her children.

It’s been about 15 minutes and HK asks: ”I have only met Valeria a couple of times and I think she has made some progress in her limit-setting with Johanna. It has been only a short while though and I understand if there is no change here yet, but I wonder how you (the staff) will notice when things will be getting a little bit better?”

One of the nursery school teachers immediately answers: ”It will be much calmer and the children won’t cry as much when Valeria leaves.”

”Valeria will be on time,” the administrator says and one of the teachers who hasn’t said anything yet nods her head and quietly fills in: ”She will be more strict with the children when she picks them up and there will be no more fuss with coats and shoes.”

Through a series of questions on the same theme to the staff and the social worker, concrete behavioral descriptions of what will be different are filled with more and more details. When HK thinks that the depictions are concrete enough for everyone to see if and when they occur, he turns towards Valeria:

”What do you think about all this? How will you notice on them (HK makes a sweeping gesture towards the staff) when they notice that you have changed?”

”They will meet us when we get here in the morning and they will help me undress the children so that the children feel that they are welcome.”

”How will they be different towards you?” wonders HK as he raises one hand with the palm towards one of the nursery school teachers, who is trying to say something, and adds towards her: ”One moment.”[22]

”They will tell me more about how things are going with the children in the nursery school, not only the bad things that happened, but also if something good happened.”

”How will that affect you?”

”I’ll be happier and it will be easier to talk to them.”

HK turns toward the staff again: ”Have any of these things happened during let’s say the last two weeks?”

”Yes,” one of the staff answers, ”the other day Valeria seemed to be entirely ok and the children were ok all day.”

”Oh,” says HK, ”so it makes such a big difference. How was Valeria different?”

”She seemed harmonious and there was no fuss with the children.”

The other nursery school teacher now suddenly remembers that there was another day when things were better too and when the staff collects one observation after the other, a picture of big changes the last two weeks slowly emerges. Valeria also starts describing things that the staff is doing differently towards her.

”So if you pick a scale from 1 to 10 where 10 stands for what we imagined it would be when the problem is solved – what has this last week been like?”

Valeria looks nervously at the staff who seems to be consulting each other with their eyes. Finally one of them answers “7,” and another nods in confirmation.

”Wow,” says HK, rises and shakes Valerias’ hand. ”Congratulations! How did you do that?”

Valeria smiles proudly and generously blames him: ”It’s because I’ve been seeing you.”

”Maybe so,” answers HK, ”but *what have you done* that has been so different so that they (a sweeping gesture towards the staff) have noticed the difference?”

The rest of the meeting deals with these descriptions and how the staff and Valeria have collaborated in a change-process. From this point on it becomes a positive and hopeful meeting and plans are made jointly around what each person can continue to do that will enhance the chances of procedures around leaving and picking up children will continue to function without complications.

Special difficulties and a few tips

Our experience is that there are two types of situations that can be particularly difficult for therapists. One is when someone wants the authorities to force a relative into treatment, and they are the only ones who feel that the situation is so serious that this is necessary. One example is Mrs. Anderson who comes to the Alcohol-clinic very concerned and worried because her husband drinks one light-bear with his dinner every day.

It is important not to ignore Mrs. Anderson. It is not because we don’t understand how one light-beer a day can be a problem that it is not a problem. One way to relate is to examine how Mrs. Anderson will notice the difference when her husbands’ problem is solved.

The other situation is when social workers are extremely oriented towards a particular method of treatment. We think this will be as common in the future as it has been in the past. The difference will be in the preferred theoretical orientation. In the past every addict

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[22] HK considers that it will not benefit the co-operation to have a discussion about whether the staff meet Valeria in the morning or not.

was to be treated in an institution. In the future maybe everyone is to be treated with 30 days in an AA-institution, or maybe everyone is to have brief solution focused therapy.

It's wise to keep in mind that social workers, as well as therapists, are bound by the ideology that dominates their unit. A meeting, focusing on the client's and the family's goal and their ideas on method, can sometimes lead to a social worker fighting for these against her own institution.

CONTINUING THERAPY

General and specific

Sigvard, 41 years old has been using (hashish, alcohol and heroin) for 29 years. In the fourth session he incidentally mentions that he hasn't smoked hashish for three-four days.

"How did you do that?" the therapist (HK) asks, and leans forward. Sigvard answers that he was terribly irritated and that he even pulled a knife against one of his colleagues at work. The colleague told the boss that Sigvard took an extra break.

"So how did you do not to smoke hashish"? the therapist asks again.

"It helped to drink tea, smoke cigarettes and build violins", answers Sigvard.

Since the therapist remembers that one part of Sigvard's 'miracle' was that he would be able to handle his temper better he asks:

"How did you do it not to knife your colleague when you got pissed at him?"

"I got so angry I could have killed him", answers Sigvard.

"So how did you do it not to?" the therapist asks again.

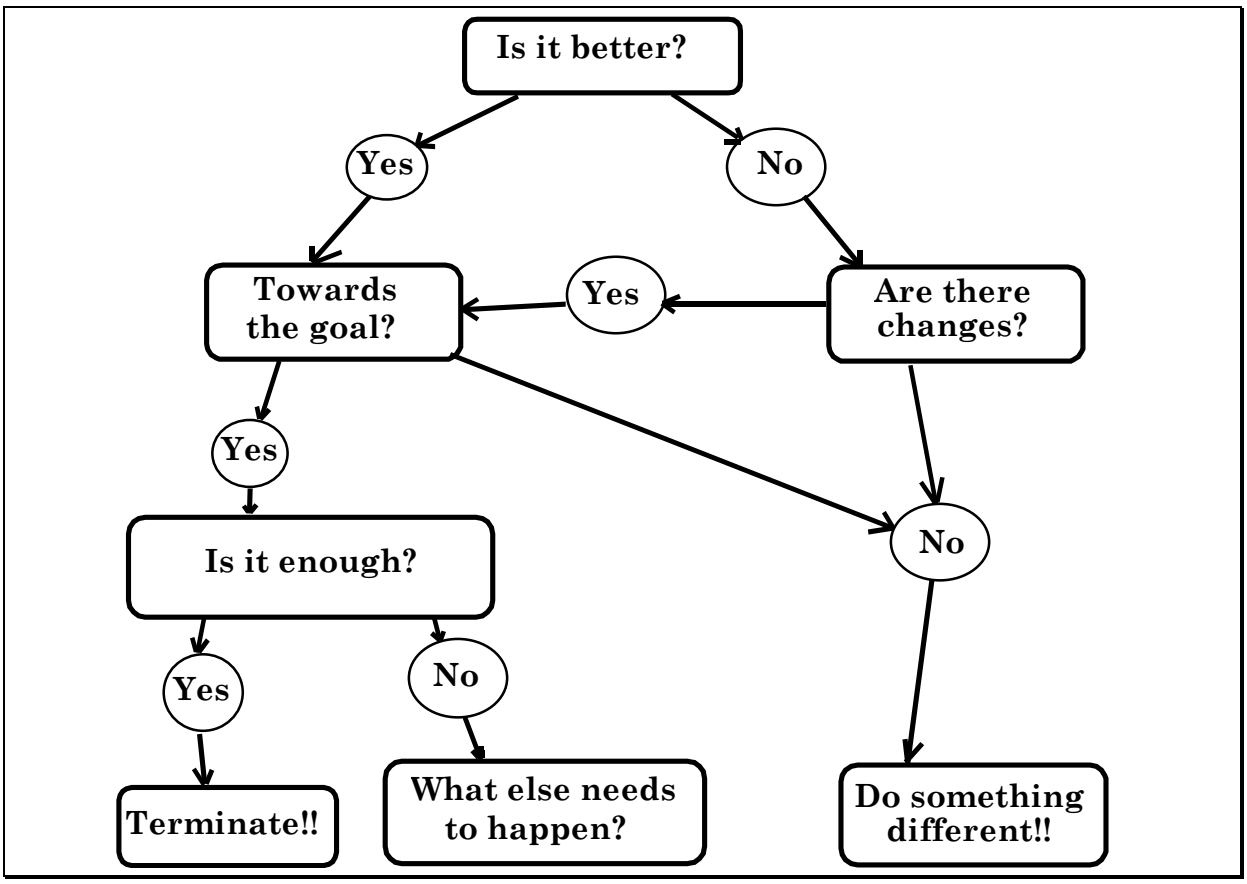
"I went out and walked around the block."

"Was that something new?" the therapist asks, and Sigvard recounts that in situations like this he always hit first and thought after, but this time he said to himself that he had to keep his job and 'instinct' told him he had to get out.

"Fantastic," says the therapist. "What else did you do?"

It often seems that clients don't hear our questions until they are repeated for the second or third time. We believe this is because people in the mental health business (clients and therapists alike) tend to think in a problem-focused way. Our questions focus on how Sigvard stayed away from hashish, what he did instead, and what and how he does when he follows a constructive impulse. These are unusual questions for Sigvard.

We used to start sessions by asking our clients if they had had any thoughts about what we talked about the prior session. Today we are interested in what they or others did differently since we met, how they experienced that, and what they think about it. We feel this difference is an important one because it points to the fact that what is important now is what people do in their life, not what they do in their therapy. Expressed differently: We are interested in peoples lives between therapy-sessions, not in therapy-sessions "between life".



With permission from Steve de Shazer

The flow in second- and subsequent sessions is very similar and is well illustrated by the scheme above (reprinted from Clues to Solutions). What distinguishes is the clients unique descriptions.

Is it better?

”What have you done since we met last that has been good for you?” or ”What is better?” are two typical questions that start all sessions after the first. It is not uncommon for clients to answer that nothing is different, that everything is the same and that they didn’t do anything that was good for them. This doesn’t discourage us since we have difficulties believing it. If people have survived this long, under such difficult circumstances, this is by itself a sign that they have a lot of resources and that they do a lot of things that at least lead to their situation not becoming any worse. Instead we then ask for differences:

”What has been different?”

”Has any day contained a little piece of the miracle (the goals the client and you described in the first session)?”

Sometimes we get only unclear or negative answers to these questions. If so we ask about each day since we met, or at least about each day during the last week. We then often find out that the same day we had the first session (or the prior session) and the day after, were good days. The client felt better then ordinarily or did some of the things that were part of the goal. We then get deeper into that:

”How did you do that?”

”How did you succeed?”

”Where did you find the strengths and resources to do that?”

”Who, how and what was of help?”

”Who noticed and how did they react?”

Clients then often remember things they did other days. We get into these occasions in the same way thoroughly examining each of these behaviors or events:

”This is what you wanted to happen – wanted to be able to do!” we exclaim surprised and impressed. ”How did you do it?”

We have been surprised many times by how clients through these questions completely change their view of the last week or month, sometimes in less than 20 minutes. Nowadays we are not very surprised. We know now that meaning is not created and maintained automatically around behaviors that hasn’t meant anything for a long time. (See for instance when Cilla enjoys the apple page **16**.)

Is it enough?

When we have a clear picture of what has been different, and when we think that the clients also has a clear picture, we try to get an idea about how satisfied the client and family are. We usually ask: ”Let’s assume that the three months to come will be as good as this week has been. Would that be good enough?”

Sometimes it is obvious that the question is not relevant. Perhaps the differences are to small, or maybe there is only one good day in a very difficult life. But often there are many good days, and many times the clients did everything or at least a lot of what they described in their miracle or goal-descriptions. When this is the case, the question is very relevant. They often answer: ”It would be perfect,” or ”it would be more than enough.”

We then wonder how sure they are about their progress and we continue with scaling questions: ”If 10 means you are absolutely sure that you can make the next – say 4 weeks – as good as last week and 0 means the opposite, where are you at now?”

When a client has reached the conclusion through these questions that things are good enough, and the client is certain that he can do as well in the future, it is natural for us and for him to terminate treatment.

Better – but not enough

It is however common for clients to come back to second- third and fourth-sessions and things are certainly betters but not enough.

”What else needs to happen?”

”What else needs to be different for you to feel/think that it is good enough?”

”What else do you need to feel that you can handle?”

”What else do people around you need to see for them to think that you don’t need us any more?” are questions we supplement with.

As always these questions are developed in the same way in relation to time and to other people.

”If 10 means that this week has been perfect and 0 the contrary, how high do you think your mother would put you this week (day)?”

”What needs to happen for your father to put you ½ point higher?”

Good enough – but not sure

It often happens that things are good enough, or that the goals were reached at least some of the days, but the client is very uncertain as to his capacity to bring about more such days. We then think, ”the client doesn’t own his change”.

> Donalds goal, as formulated in the interview is, ”to resist the urge to sniff gas on boring days”[23]. He sniffs only when he is bored, and therapy didn’t progress for a long time as the therapist (HK) thought that the goal was to help Donald make every day a non-boring day. When Donald succeeds in resisting the urge it is totally incomprehensible to him how he did it. He knows it helped to draw pictures, go for a walk, talk to his mother, play with the dog and 7 more things. He seems to know that it helps to do other things, but how he succeeds in doing these things he doesn’t understand.

Questions we then ask, deal with what the client needs to do or see happen for him to be more certain that he can continue to do these things that are good for him.

”Ok, so you’re at 5 when it comes to confidence in your ability to continue to do these things. What do you need to be able to handle for you to feel that you are at 5½?”

Sometimes this attitude stand for the client thinking that we can be of help to get much further than maybe we thought was possible.

> Caroline has been in treatment for a long time and has made tremendous progress. It is difficult to believe that she has been a ‘bag-lady’. Her mother and her child’s foster-parents are impressed and amazed by her progress, and so is her social-worker and one person at the employment-agency. The therapist (BA[24]) doesn’t understand why Caroline puts herself only at 5-6 on a scale that has to do with how well things has been going lately, and she repeats the question three times. The supervisor (HK) phones in and asks her to explore what would be 10 for Caroline, and Caroline tells the therapist that she would like to become a medical doctor. Caroline’s 5-6 then suddenly seems perfectly relevant and the interview continues with questions around what needs to happen for her not to need treatment any more.

No change or improvement

Sometimes we don’t succeed in creating descriptions that contain any progress. It seems that the first-, second- or third session just didn’t make any difference, things are simply no better and maybe even worse.

When this happens it is wise to go back and reflect on if there is a useful goal. We can cautiously ask clients why they continue to come to us, and if and how it’s helpful, but we are not satisfied with answers like: ”It’s nice talking to someone.”

We go back to questions that belong in the first session: ”What is your problem and how will you/others/me notice when things are getting better?”

We then often find new or maybe different, more relevant and useful goals than we got in the first session.

This development or lack of development guides us into thinking that we have to do something different. It may be finding new ideas about goals, or carefully reevaluate the relationship with the client. Sometimes we may have misjudged the relationship and have suggested ‘do-tasks’ to a client who thinks the problem and its solution is dependent on someone else’s behavior, and it would have been more relevant to suggest ‘observation-

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[23] Goal formed by Donald and Steve de Shazer in a consultation interview.

[24] Birgitta Andersson, Day-care Center Balzar, Malmö.

tasks'. Sometimes we realize that we totally misunderstood the reasons a client or family-member had for coming to us.

Something different we always try to do is to see more people, fewer people or other people in the client's network. We often have a colleague make a consultation-interview and sometimes we refer the client to another therapist.

Concerning clients who come to treatment in order not to do something else (like for instance go to prison), it is particularly important to use the possibilities of flexible encounter that are built into the model. It is ok for us to see a client a couple of times because the client has to come to treatment, but things must get better or different for us to continue. If the situation is not changing we ask the referring agent to participate in a session to renegotiate the goals of treatment. If nothing happens after this we see no reason to waste the clients or our time. We terminate treatment with an offer to the client to come back when and if he thinks our ideas can be of any help.

Interval between sessions

We have experimented with different intervals between sessions. One week, two weeks, one month. Nowadays we simply ask the families and the clients. However we do have an opinion that we show clearly; the longer the clients and families can make it on their own, the better.

When clients come to the first session we usually ask them if they think that one or two weeks is best before the next session and when change is starting (most often in the second or third session), we usually suggest twice as long until the next session. Should the client insist on seeing us earlier we do agree however. We usually understand this as an expression of the client's confidence in continuing the change process not being high enough and we respect this.

After this we usually suggest about a month between session. When a client thinks that the changes seem stable, but still expresses some uncertainty around termination, we suggest three or maybe even six months until the next session. We sometimes add "let's set up an appointment, but call us when you have reached the decision you don't need it."

Clients who fail to appear

We talk some about no-shows when we talk about terminating treatment (page 126). It would be naive though not to talk about such failures to appear that occur because the client started to drink or started to use more drugs.

When clients come for therapy with family members 'no-show' is generally not a problem. If the client doesn't come to a session the family almost always gets in touch and we can discuss with them if and how we are to continue. Many times calls from family members simply leads to setting up a new appointment, and it's the relatives who make the client come back to the next session.

The situation is not complicated either when it's an authority that has referred the client. Most often there is an agreement about what to do *if* the client fails to show and one just follows the agreement.

With clients who seek treatment by themselves we often raise the issue in the first session.

”Who shall we call *if (note; not when)* you don’t show? Who can make sure we can continue even if you should mess things up?” Most often these questions lead to the agreement that a family member should be informed about the ongoing treatment, and many times this leads on to that person being invited to a session.

Tips on goals

Some clients seem to think that “time” will determine if things are well enough. These clients say: ”I have to be off drugs for three months or six months, and after that I will know my problem is solved.”

When clients see time as one of the most important parts of their goal, the other part will consistently be not doing a certain behavior; ”not do drugs”, ”not drink”, ”not binge” or ”not have tempers”. This means that the therapist is breaking ‘dead mans rule’ (see page **92**) and neither the client nor the therapist can ever know when and if the problem is solved. Even after 40 years of abstinence the client can still start drinking again.

Problems often arise in these therapies when the client has been abstinent for some time and doesn’t know how he did it. Commonly the client or some important person in the network will be dissatisfied with the result of treatment and relapses seem to be more common.

It may be useful in these situations to define the reason for improvement as a mystery, or even to define the reason things isn’t getting worse as such. Preconditions for change exist when clients try to find answers to why and how they made some improvement.

With some clients we only succeed in defining vague goals. For success the clarification of the goal needs to fit, and should thus be as vague as that of the client. Scaling questions are then very useful. The difference between 5 and 7 on a ‘happy-scale’ or a ‘feel-good-scale’ can be the difference needed by a client to feel that he is moving towards his goal, and the therapist don’t have to understand what the client means by this difference. It’s enough that the client creates his own meaning.

RELAPSE

Relapse is a word therapists and clients tend to use often. ‘Taking a relapse’ is considered a normal thing or at least something happening often in the course of rehabilitation. The denomination is often used routine-like and without reflecting on whether other denominations or descriptions could be more useful for our clients.

The word is used the same way as many other words in our language. By denominating (naming) a combination of complex behaviors, our clients and we believe we know the meaning of those behaviors.

Every time you think someone ‘took a relapse’ or ‘relapsed again’ we think it is wise to think what it means to you. Many dedicated therapists gets deeply disappointed when a client has a relapse, especially when things has been going better for a while and one starts discerning an improvement in the clients situation. It may be of great importance if a relapse is described in terms of ‘a relapse’ or if the description becomes something like:

”Janne only took two shots this time. He cut loose immediately and so fast, that for the first time he could kick heroin without pills.”

The addict and his family come to the fifth session. The client reports that he has ‘taken a relapse’ last weekend and he feels terrible about it. He has been off drugs for 4 weeks and has sensed real progress in many areas of his life. Everyone is disappointed, and maybe even you have a nudging feeling and wonder deep down inside if it is really possible to help addicts with only outpatient brief therapy.

It is often impossible to talk about anything else than the ‘relapse’ and the client himself is either very anxious to do so, or shamefully reticent and evasive. Many times ‘the relapse’ is seen as part of the usual pattern of periods with abuse, interrupted by short periods without. The clients own thinking often seems to circle around ‘why did I fall back?’ and that is also most often in the minds of relatives and professionals.

Don’t let desperation spread. Take a firm grip on the session and make up your mind to find out what has happened so you don’t passively accept denominations and denigrating allegations about the client or others, pronounced in the beginning of the interview.

With the questions below you focus on the relapse but on two different aspects. On one hand you focus on what the client did to terminate the relapse, and on the other; on what was different this time. It is important to investigate both these aspects in order to obtain different and useful descriptions of type; the relapse was shorter, less intensive, had less consequences for relatives, for work or school or anything that is important and useful in the client’s life. Talking about this makes the people present feel that you care about what is important without digging yourself and them down into the failure.

Open up space for – and confirm – pain, disappointment and grief both with the client and the family.

”This has really been tough for you.” ”Incredible you could stand the pressure of him starting to drink again.” Etc.

You shouldn't let this dominate though, as this will inevitably lead to accusations. Remember that dedicated and angry people need to feel confirmed and understood in order to be constructive.

Is the client sober?

Ask then:

"How long did it last? Was this relapse shorter than the one before? What made you break earlier than ordinary?"

"In what way was this period/this relapse different? (How long, where, with who)".

"What made you decide to stop the drinking/abusing/eating?"

"What did you do this time that helped you stop turning on/stop drinking? What strategies did you use? How did you succeed with it?"

"What people was of help and what did they do?"

"What was new/different?"

"What did you learn from doing in this new/different way?"

Are relatives or professionals present?

Ask:

"What do you think made him decide to abuse for a shorter period of time/in a different way?"

"What did you see him do to stop?"

"What did you he/she/you/others do that helped him decide/helped him do something different?"

"What was different for you during this period/this relapse?"

If the professional network is not present it can be useful to ask the client the same questions but in terms of "if ... was present, what do you think he'd say was different and new, and how would he describe what he did or tried to do to help you?"

Is the client drunk or high?

Ask:

"How did he manage to get to the session?"

"What made you (the client)/him/her decide to come here despite his condition?"

"What did you do that made him decide to come here?"

"What did they do that made you decide to come here?"

Goals and denominations

Work with such behaviors that are usually called relapses started already in the first session and the center of that work was the client's goal. We can not emphasize enough the importance of you listening for goals that contain other things than "the absence of the problem". Dead mans rule is a very good rule. It means that you confirmed and developed such aspects of the goal that can only be done by people who are alive. We have thus dissuaded from goals like; not drink for six months, not drinking at all, not

have any relapses. That is – goals that can easily and successfully be performed by dead people. You should remember that goals should be small, possible to attain in the client's actual context, described in behavioral terms and described as the beginning of something rather than the end of something.

If and when a relapse occurs, it can and should be related to the goal(s) the client has set for himself: "These three days of doing drugs – do they affect your chances of doing such things you want to do?"

"How does this relapse (alternatively this period/ test of your ability) help you do more such things that you want to do?"

"What do you need to do to get back on track?" (only if the client seems to have gotten off track)

Via these questions you and your clients will sometimes reach the surprising conclusion that a relapse doesn't need to have anything to do neither with the problem nor with the solution.

For you and your clients to be able to feel and think in this way, it is necessary that at least you keep the goals clearly in your mind. Both you and the client/family need to believe, think or feel that there is a movement in the client's life in line with those goals.

Jon's summer has been OK, and he has had some success with girls. In the fall he starts high school and starts smoking hashish again. His mother calls and makes an appointment for him as she thinks he is behaving badly. When he comes he states that it is mother who has a problem with his behavior, not him.

He has no plans to stop smoking hashish, but he *wants to make it in school, be calm at home* and he *wants to develop his social life.* He describes what he wants his social life to look like. Go out, meet girls, being able to talk to people and have something to say. At home he wants to be able to cope with his mothers nagging and her telling him what to do, and he wants to be able to respond calmly to her. The goals are small, concrete and seem possible to achieve in his actual life-situation.

In the third session he has suddenly decided that he wants to stop smoking hashish again: "I need to in order to manage school." He has resisted the urge for two days and with HK he talks about how it is to talk to girls and what he needs to do continue in the direction he has chosen.

He looks ashamed when he appears at the fourth session one week later and is not as talkative as usually. After a while HK asks him what he is sitting on. He then recounts that he didn't smoke hashish for eight days but now he smoked yesterday and the day before. HK wonders what was different when he *didn't* smoke.

"Nothing", he responds "I did the same things with the same people as usually, and it's been boring."

HK insists several times: "What was different when you didn't smoke? Something must have been different!" and eventually Jon gives in and recounts that Anna talked to him. She doesn't normally do that because she doesn't like hashish-smokers, and the proof for this is that she hasn't talked to him for the last two days when he smoked. "She doesn't even say hello," he says resentfully. "How does she know you didn't smoke?" asks HK and he answers: "One can tell." HK wonders: "How?"

"You can tell by my eyes," he says, and HK wonders what else is different when he doesn't smoke: "What is it Anna sees with you that makes her think it's worthwhile talking to you?" He answers:

"She doesn't talk to me, she doesn't even say hello."

"She talked to you when you didn't smoke those eight days. You must have been different if you didn't walk around with a flag saying; today I smoked and today I didn't!"

Eventually Jon bends to the evidence and admits that he probably was more sociable and talkative those days when he didn't smoke, and after this he shyly admits that he called Jenny

(whom he has thought about for months). He talked to her on the phone and he didn't feel his usual blocking, like not knowing what to say etc. On a scale from 1 to 10 it was as good as 7-8.

"Wow," says HK, rises and writes on the flip chart: "Talked to Anna, called Jenny. What else?"

"He thinks for a long time, and HK tries to help him by connecting to the goal: "Was it calm with your mother?"

"Yes," he answers, "we went and saw 'Swan-lake' last Friday".

"Wow," HK says again, "is that the kind of things you like to do?" Jon looks at him coldly but with a humorous twinkle in his eyes and says: "Let's say I prefer to go to the movies."

"OK," HK answers, "I'm not to fond of ballet either, but was it fun to do something with your mother?"

"It was OK," he answers briefly and HK adds GOOD AT HOME to the flip chart. HK then stands and looks at what he has written, draws a circle around the three things (called Jenny, talked to Anna, good at home) and says:

"Aren't these the kind of things you wanted to develop in your life? Be successful with girls, that is talking to them in a natural way, and have a nice time with your mother?" He admits this and HK asks: "So what else do you want to develop?" He thinks for a while and says:

"Something has to change. Something has to happen – something new." HK adds this to the flip chart: CHANGE, SOMETHING NEW, studies the flip-chart for a while in silence and asks:

"So what do you have to do to continue to work in this direction that you have here and have at least partly succeeded, and besides increase your chances to do something new and different?

"What do you mean succeeded?" he asks and HK explains: "You did this talking to girls as well as 7-8, and that says something about your ability, doesn't it?" He agrees and now looks very thoughtful. HK continues: "This was really quite different. What actually surprises me the most is that you made such big changes even though it was only your first week without hashish, so what do you need to do to continue this development that you want?"

Jon looks at him helplessly and says: "It's hard to stay away from the pot." I know," HK answers, "it's hard work, so what do you need to do to continue this development that you want? Being more sociable and all that. That is if you want to." Jon thinks for a long time and doesn't answer. "If you want to," repeats HK, "it's your life". Eventually Jon says: "I want to, but it's difficult."

HK confirms: "It's hard work, but you've already shown that you know how to talk to girls and you can be pretty decent at home and at school, so you've already gotten a bit of the way."

The conversation only goes on for a short while after this. Jon thinks that his chances are about 70% that he can manage the week after without pot and HK sums up before he leaves: "It's good you did this test now. I think it's useful for you to make the difference so clear to yourself." Jon nods in agreement and a new appointment is set up.

Relapse or not

Sometimes it is not clear what is a relapse

A 'bulimic' woman comes to her third session. She has vomited the day before. A relapse she says and she brings with her an overwhelming sense of failure. It takes more than 20 minutes into the session, before she reveals that before 'the relapse' she had 5 days in a row when she succeeded to keep her food. It is the longest vomit-free period for six months. The rest of the session deals with examining in detail these 5 vomit-free days.

Seeing her 'vomit-day' the day before as a relapse would be a serious mistake from our perspective. In the session we are impressed with her progress. Five days without vomiting is reason to carefully examine how she did and infinitely better than the 7 'vomit-days' the week before.

A relapse is *a significant step backwards*. What is experienced like that varies from person to person, from situation to situation, and is very much dependent upon how one talks about it (the denomination and the frame it is given).

The denomination

It is not strange that a client will test if he can manage to have the positive effects of drugs, alcohol, food, gambling, etc. after he has had a period of abstinence. If he comes to conclusion that it is impossible this can be described as 'insight-full', 'a successful experiment', 'a test' or any other word that can describe what happened without being colored by all the negative feelings that follow with the word/description/ relapse.

Most people can function socially and have a drink now and then. It is not strange if addicts check if that works for them too. (A larger proportion of former alcoholics drink 'normally' than are abstinent.)

To create these more useful meanings, more complex descriptions are needed than 'he took a relapse'.

Relate behaviors to the goal

When behaviors are connected to the goal a new description/denomination with different significance is created.

If Manfred's goal is to be able to *drink like anyone* and this means to him that he shall be able to share a bottle of wine with his girlfriend on Saturday evening, than half a bottle of wine on Saturday evening is not a relapse for him even if the girlfriend considers it to be one. If this isn't clear to you, the girlfriend and Manfred, you will never find a working solution together.

> A relapse is still a relapse. It doesn't matter what the hell you call it, or what do you mean?"
>
> Manfred is angry. The answer is a reaction to the therapist (HK) who suggested that what Manfred thinks he is doing since three days is not a relapse, but a test of whether he can handle alcohol. The therapist answers calmly: "Maybe you feel like that, but you're sober now aren't you?"
>
> "Yes," Manfred answers reluctantly and the therapist continues:
>
> "I don't get this. For how long do you usually drink when you start?"
>
> "Well, something like three weeks."
>
> "How long did you do it now?"
>
> "I had a glass of wine with supper Saturday evening and after that I got this need for a bracer and then I started drinking on Sunday evening and it went on all through Monday."
>
> "When did you quit?"
>
> "Yesterday evening. I haven't touched a drop since six o'clock."
>
> "OK, now we are Tuesday afternoon so that means you drank for 24 hours."
>
> "Well, I started drinking Saturday, so it was two days," Manfred answers.
>
> "Two days?" wonders the therapist. "Do you call a glass of wine Saturday evening, drinking?"
>
> "No, but it is always like that. It starts with a glass of wine at supper and then I can't finish. I empty the whole bottle and then I'm on it."
>
> "OK," says HK, "so what was different this time?"
>
> Manfred thinks for a long while and then answers tentatively: "I drank only a glass of wine in the evening and I didn't finish the bottle until late the day after."

”Fantastic,” says the therapist and Manfred looks at him with surprise. ”You almost succeeded. You drank only one glass of wine and then you left the bottle alone, and when you started drinking the day after you stopped almost immediately. How did you do it?”

”I thought about not wanting to fall back into the shit.”

”What else?” wonders the therapist.

”I decided I wanted to come here sober, and I thought that if I continued drinking, I would miss seeing my daughter next week-end, and I don’t want her to get disappointed with me again.”

”OK,” says the therapist, thinks for a long while in silence and then asks: ”On a scale from 1 to 10 where 10 means that you have arrived at what we talked about six weeks ago. That is, drink a glass of wine at dinner and then not drink more, how far do you think you’ve gotten?”

”Well, a 3 or a 4” Manfred answers and continues: ”Well no, maybe 5. It went well in the evening, I only drank one glass of wine. It was the day after that didn’t work”. He pauses, thinks carefully and goes on: ”The next time I make a test I’ll make sure I have something important the day after that I definitely don’t want to miss. Then I don’t risk falling back.” He pauses again, slowly lifts a shaky hand that he looks at thoughtfully smiles and says: ”I think I shall wait a while with that.”

The therapist laughs and says: ”What do you have to do now so that these two days continue to be a parenthesis?”

”I have to keep myself occupied, and remember that I am seeing my daughter Saturday.”

In sum – four themes to think about

- Focus on the denomination (the word) ‘relapse’.
- Focus on how this ‘relapse’ was different from other relapses.
- Focus on how and what the client and others did to stop the ‘relapse’.
  If the client is under the influence it is of course not reasonable to try the third above (as it hasn’t happened yet). Try with, ”How did you manage to pull yourself together so you could get here today”?
- Focus on the goals. Preferably in terms of how would this have been different after the miracle.

Particular situations

The client is under the influence but pretends nothing is wrong

Anton:

Anton, 45 years old, has abused sedatives for many years. The situation has improved in the first five sessions, but when another two have passed and Anton is thoroughly and increasingly intoxicated, the therapist (JL-K)[25], brings up that she feels that she is not of any help. Anton assures her of the contrary and talks about things that were much worse before. When questioned as to what he thinks his relatives think about the situation he avoids answering. It appears that Anton now again only sees his parents and brother sporadically. During the time the therapist thought that Anton was doing better, he had more contact with them.

[25] Jocelyne Lopez-Korman, Avenboken out-patient center, Malmö.

The therapist is still not convinced that she is of any help and finally states that she needs to see the brother to get his opinion. Anton is hesitant, but the therapist sets this as a condition for continuation, as she is hesitant as to whether or not treatment is making a difference. Anton finally accepts and when the brother is involved in therapy Anton makes rapid progress and quickly becomes totally abstinent.

Bert:

Bert, 30 years, is court-ordered to go to therapy and has been off drugs for three months since he got out of prison. He has been going to school, he has not taken any drugs, and he has regained contact with his parents and siblings. He also got a girlfriend. These four things were all in his answer to the miracle-question in the first session. In the seventh session he recounts sadly that the girlfriend has broken up with him. His speech is thick, but he doesn't say anything about having drunk or taken drugs.

In the beginning of treatment the probation officer participated, the family then relayed him and since some time Bert is coming alone.

Previous question concerning how the family and probation officer would react if he had a relapse have been answered with "They'd give up," "They couldn't cope with it one more time," etc.

The session is focused on how the network would react "if they knew what a crisis it was for him that his girl-friend broke up?" and he recounts thoughtfully that he hasn't shared what happened with anyone. The therapist[26] wonders who would understand him best and he mentions his brother first and after that his mother. "Would it help you not to get involved in drugs if they knew and were there for you?" the therapist wonders and Bert answers: "It probably would."

In the summary of the session the team and the therapist suggests that the family and the probation officer should be invited to the next session, and Bert accepts.

He shows up sober to that session and tells his family and probation officer about his relapse and how thinking about his family helped him stop it.

In these two cases it was helpful to involve more people in the sessions. In other cases where the family participated and the change-process stopped or went in the wrong direction, we have reduced the number of people instead. The rule is always: If it works – do more of it. If it doesn't work – do something different.

Disagreement

Sometimes there is disagreement in the family, in the professional network and maybe uncertainty with the client himself if a given behavior at a certain time, that maybe occurred and maybe didn't, was a relapse or not. Sometimes it can be extremely important for someone to get a clear label, for instance when a parents drinking is putting children at risk, or when an employer can not risk having a drunken employee on the shop-floor.

By discussing and reflecting upon what is a problem for whom, and through descriptions of *non-problematic behaviors* in that persons/authorities perspective, the situation will get clearer for everyone involved and it will become clear to the client what is expected of him.

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[26] Jocelyne Lopez-Korman, Avenboken out-patient center, Malmö.

Finishing remarks on relapse

Is there any difference?

Be observant. If you can't describe any positive changes in this relapse compared to the last (or treatment doesn't seem to make any difference) you should seriously consider terminating treatment. If things are getting worse instead of better, it is probable that you unwillingly have become part of the problem and is not a part of the solution. You should then consider withdrawing from the situation in order not to aggravate the situation even more for your client and his/her family. At least you ought to discuss it with them.

> Aina, heavily addicted for many years has been coming to sessions sporadically for a year. She comes in after her fourth period during the year – a month spent with the street-addicts. The therapist[27] brings up if she should continue treatment, as these relapses are so destructive. Aina assures him with insistence that the sessions are useful to her.
>
> "Before I drank for three months in a row, and then I was sober for one month. Now I'm sober for three months and I drink one." The therapist looks a little skeptic and wonders what difference that makes in her life.
>
> "I haven't been thrown out of any apartment since I started coming here," she says, "and I have some contact with my children. This is really helping me".
>
> "Uhum" says the therapist and wonders, "so what is the next step?" She reflects briefly and answers:
>
> "That I drink for a shorter period than two weeks and that I don't miss the visits to my children. They were so disappointed this last time.

A similar example where the therapists wonders if the treatment is of any use, leads to some important information.

> The social worker looks terrified when Andrea 45, recounts that every time she has had a session she has had a beer in the evening.
>
> "Oh," says the therapist[28], "if so we probably must stop these sessions."
>
> "No-no", says Andrea, "I can handle drinking *just one* beer after I've been here. I can never do that at other times."

[27] Jehoshua Kaufman, Avenboken out-patient center, Malmö.

[28] Jocelyne Lopez-Korman, Avenboken out-patient center, Malmö.

SPECIAL DIFFICULTIES AND PARTICULAR SITUATIONS

When addicts have children

Many addicts have children and many children live with their addicted parents. Therefor the therapy-room can not be separated from the world outside. One can not make purely therapeutic considerations.

In Sweden the social services act says that you have to report to child protection agencies when you think that children are at risk and we think that this should be considered every time you meet addicts who are also parents.

There is no difficulty to decide on reporting when you meet a tired, worn out heroin addict, who is clearly incapable of taking care of her new-born. It is not particularly difficult either, when you meet a man who drinks every third month, but lives in a stable marriage with a sober wife and well functioning children. Difficulties arise when you work with Sofia who has a three-year-old, uses drugs with varying intensity and shifting interval and then relatively systematically (but maybe not always) leaves her child with her mother. Deciding the limits is often impossible. Is it OK that Anna is drunk once a month? Twice a month? Twice a week (Friday and Saturday evening)? The decisions therapists have to make are often impossible.

What is best for the children? Do I have to report to child protection or can I treat and see if it turns out all right? Can I help the parents/addicts become free of their addiction and at the same time take care of their children in a good enough way?

When we become more skillful it doesn't make things any easier. We tend to think and believe even more often that we can help parents into a future where the addiction is no longer a problem, and we know that reporting will risk the cooperation. Will she stay sober so that the children won't have to be committed, and if I report – will the investigation create more problems than it solves? It's not uncommon for therapists to develop a habit of delaying reporting in the hope that changes will come.

The dilemmas that therapists face are real, difficult and painful. Every situation is unique and there are no clear-cut rules.

What is best for the children?

Children have the right to grow up under secure conditions and get the care and stimulus they need for their development. The safety and calm needed for this can not be provided in a home where one or both parents are heavily addicted.

At the same time we know how important parents are to their children, and we know that children placed in foster homes do not always fare all that well.

What is parental support?

The most important support for new parents has almost always been their own parents. It is of help when parents and relatives trusts in ones competence and at the same time provide encouragement, positive support and practical advice. For relatives of addicts this may be very difficult. They see so much of the ill-effects of the addiction and most of the time they are very worried. They often feel they are nagging and worse, without any effect. It's obvious that their child and grandchildren needs them but despite this, it is as if they were just banging their head against the wall.

It can be very useful to work with three generations. Many clients need – and want – clear limits for tolerable behavior, even when they protest against what the family is saying. Your support to the family can make the difference for relatives in order to gain enough energy to both pressure and support in an efficient and meaningful way.

What addicts need from the professional network is in many ways the same as that of the family – support, constructive criticism and clear and unambiguous messages. The difference is that the family does this for personal reasons while professionals do it for professional reasons. The pressure and the support from the family and network are both important and can together make a difference that makes a difference.

The work of the therapist

It is important that the main focus of treatment is in line with the request and it is the 'commissioner' who decides. When Norbert wants to work with his relationship with his wife we try to help him with this, as we think it would be pointless trying to create meaning around behaviours that are exceptions to our idea about alcohol making him a bad parent. When we go with his ideas about problems and goals we also see that several of the goals lead to – or are connected to – more responsible behaviour towards the children (see Norbert page 19).

If the clients goal has to do with the addiction, the main focus should be on this. If the client aims at being a better parent or husband one should work with this. It is unavoidable though that development of competence within one area leads to development of competence in other areas too. Independently of the complaint or problem, it is almost always possible – and always desirable – to connect progress within one area to progress as a parent.

What to do

Helping addicts with children will most often (always?) comprise aspects of the parental role. When we ask for goals we are careful in trying to help parents imagine how their children will notice on their parents *when* they have reached their goals, and how they think the children will be different then. When parents express that they have no problem in being parents, or that their problem doesn't interfere with that part of their life, we normally accept this initially, but we always come back to it one way or another.

We always assume that clients wants what's best for their children, and we also assume that clients don't want their children to grow up with addicted parents, so we ask how the client will do *if* things don't change for the better.

Clients have ideas about what it means to be a parent. Questions inviting clients to think about this are for instance: "If 10 is your idea of a perfect parent, how good are you when you don't drink or do drugs?"

"How good are you when you are using drugs?"

”On a scale from 1 to 10; how important is it for you that your children can live with you as a non-addicted parent?”

”What do you think of your chances on a scale from 1 to 10 to be a good parent if you don’t sort out this problem?”

”In what way does the children make this problem easier (or more difficult) to solve?”

When a client isn’t interested in answering these questions or has difficulties imagining what will be different with the children when the addiction is no longer a problem, we feel very worried. If this should continue over several sessions and we see no improvement in the client’s situation, we move out of the context of therapy, clarify our dilemma as persons in authority and start asking questions concerned with social control.

”How will I know that things are improving in such a way that I won’t have to tell the child protection authorities that your children are living with a parent who is actively using?”

”What do you think I have to see happen to be able to defend to my boss that I didn’t report?”

”How do I motivate to my boss that I didn’t act to have your children committed, when it was obvious you couldn’t protect them against your husband when he is drunk?”

”What do I need to tell about you handling your and the children’s situation differently so I don’t loose my permit to practice/go to jail/loose my permit?”

If the client can not give satisfactory answers to these questions, or can show positive things happening in her life, that could provide us with the facts we need not to report the situation.

When we have to report, the client will thus know that it will be done and it has been made clear why, even if the client doesn’t agree about it being necessary.

It’s important that the therapist is clear about the dilemma of being both a person in authority with certain responsibilities and being a therapist: ”I have to follow the law and this situation is no fun nor for me nor for you. You came here to get help and I have to report.”

When therapists succeed with this, it is not uncommon for clients to choose to continue treatment during the investigation, or come back afterwards.

Finishing comments

When addicts have children we believe it is important that the children are made an important part of treatment, for the sake of both children and parents.

Children have a right to their parents and for our clients it is immensely important to deal with their problem of addiction and at the same time succeed in being parents.

The area is important enough to deserve a book of its own.

Sexual abuse

In research concerning female heroin addicts it has been found that a large proportion have been sexually abused as children. Some studies have found extremely high proportions of victims of sexual abuse, in other studies somewhat lower figures. Because of these figures there has been a tendency to make a causal link between being sexually abused and abusing drugs, alcohol or food, and because of this the addict has to ”work” on

the abuse to be able to stop abusing. If this isn't done the "basic problem" remains unaltered and will cause other problems or the client relapsing into abuse.

There are no doubts that sexual abuse hurts people, but different people handle memories and experiences in different ways, and each individuals support from his environment is unique. The consequences will therefor vary. It is not possible to translate statistic truth onto individuals (at least not in the mental health field).

We do not believe in linear connections between certain types of experiences and certain types of problems. We believe that difficult experiences is one among many factors that make people more vulnerable and increase the risk that they will develop so called problematic behaviors. We don't believe these factors can be mapped reliably on the individual level. Nor do we believe that it is necessary to map and "work on" them to help people change what they want to change in their lives. The solution to a problem often has nothing to do with the problem or what caused it.

Treating clients who were victims of sexual abuse impose high demands on therapists. It takes considerable trust in – and respect for – people's capacity. It also demands patience and the capacity to endure the pain of other people. When Solveig, 24, tells about her father's brutal, instrumental raping with bottles and razors that is still ongoing, it also takes a lot of courage to try helping her to report it to the police and finally report it oneself when she didn't dare.

When a therapist meets a client alone or with the family the assignment is what they say they want help with. This is a question of confidence and respect and is valid even when the therapist strongly suspects that "the real reason" for the problem is sexual abuse.

In the following we want to illustrate meeting clients in three different situations:

- When the therapist believes the client has been sexually abused and thinks it would be valuable to work with it, or at least clarify that it happened.
- Clients who were sexually abused and don't want to talk about it. They want to work on the problem that is tormenting them in the present, whether it has to do with the sexual abuse or not.
- Clients who present themselves as victims of sexual abuse and have problems that they themselves think are a result of this.

Generally

That clients want to talk about and maybe 'work on' memories and experiences of sexual abuse, doesn't necessarily entail a detailed recounting of the sexual abuse. We understand such a demand as an expression of the client wanting to change something in their lives. Thus we see it as a mean, not as a goal per se (compare for instance with clients who wants to be on methadone, see page 38). We believe that we are helping Veronica continue her life and develop despite the horrible experiences she has had, when she tells us that last Saturday she kissed her boyfriend on the mouth and for the first time didn't feel as if she left her body.

We also assume that when clients wants to talk about the abuse, this is an expression of them already changing. We then wonder what they think about this and we ask:

"What are the signs in your life (goes on in your life) that tells you that you are on track?"

We also ask how the client imagines life will be different when these painful and difficult memories – or lack of memories – no longer causes any problems. We investigate the differences (or help the client creating them) in the clients conceptual framework

between the problem and the goal. The answers we then get often deal with being able to stay in the present under stress, being able to hug a friend or dare talking to a stranger. Questions we continue with are often exception-questions and scaling-questions: ”Do you remember any situation when you disappeared a little less?”

”Does it ever happen, ever so little, that you enjoy sex, hug a fried, dare talk to a stranger?”

”If 10 means that you’ve finished working through this problem and 0 stands for when it influenced you the most, where are you at now?”

These questions lead on to further questions such as:

”How did you do it to get from 0 to ....?”

”Where did you get the idea to do it like that?”

”Who/what was helpful?”

”With whom was it most helpful to talk?”

”How did you prepare yourself?”

”How did you do to go through with it?”

”What did you feel after you succeeded?”

”What does it make you think about yourself?”

”What do you think it will make other (your mother, your boyfriend) think about you when they’ll know you did (handled) it?”

”When this grows stronger, what will you think about yourself and others that you don’t think now?”

Many times questions such as these lead to the conclusion that the client already ”worked through” large parts of his problem and the answers often points clearly to how the client did it. The easiest will obviously then be to ask the client to continue what he or she already started with such success and continue to note more successes in the direction we have marked out together.

The therapist believes that sexual abuse is an important factor

Nowadays therapists talk more and more with clients about sexual abuse, even with clients who deny being victims – or who deny that it has any importance in their lives. When clients convey this it is extremely important to acknowledge and respect them. If they have a history of abuse it is more abuse to force them. If they haven’t been abused it is of course nonsense to continue talking about it.

Sometimes a therapist strongly suspects that a client has been sexually abused, but it is nothing the client expressed clearly. Often the client has made some more or less direct hints at it, and the therapist thinks it is necessary for therapy to acknowledge to the client that he has understood. For many clients in this situation the most important and often sufficient is that someone knows that they have been sexually abused.

If it is to be possible to talk about sexual abuse and what will be different when these memories no longer affect the client’s life, it is essential that the client trusts and feels safe with the therapist. Taking up the issue prematurely entails the risk of frightening or offending the client into terminating treatment. The client needs to feel – and the therapist needs to be convinced – that treatment is carried ahead by the issue.

On the other hand if the client makes obvious hints the therapist can not behave as if nothing was wrong. If so he or she does the same thing many others did in the small child’s environment – didn’t see nor hear – this victimizes the client again.

The simplest way to handle this situation is simply to ask the client:

”Have you been sexually abused?” or ”Did it happen to you as a child that grown-ups touched you in a way you didn’t want?” or ”Others I met with similar problems were sexually abused as children. Is it like that for you too?”

Another way is to tell a story about another client with similar problems without asking the client directly if he or she recognizes himself. This is a way to talk indirectly about what is difficult and at the same time convey that the therapist heard and understood. The client then decides himself when and if he or she wants to talk about the abuse.

A third way particularly for clients who were forced in previous therapies:

> Cornelia was committed to an institution for the first time when she was 22, because of her drug-problem. She stayed for a week. Two years later in therapy with us (HK and MS) she recounts that the seven days keeps popping up in her memory. Everyone was talking about her ‘incestuous relationship’ with her father. It was obvious to her that everyone wanted her to talk about how it was to have sex with her father, but:
>
> ”I don’t think I ever did. But I really can’t know. Everyone told me that if it happened I repressed it, but I don’t believe it happened.” Her voice becomes plaintive as she continues: ”Is it important to talk about it?”
>
> MS answers her: ”Don’t force yourself to look for it. If it is important it will come out eventually.”

The client who knows that she has been sexually abused but wants help with another problem

Some clients know that they were abused when they were children, and have talked about it in a number of different contexts in more or less useful ways and are utterly fed up with talking about it. When they seek help they are unreserved about them being incest-victims, but they don’t want to talk about these experiences. They want help with their drug-problem, their eating-problem, their sex-life or a number of other things.

Many victims of sexual abuse have already dealt with their memories in their way. A lot of clients do not feel that it is necessary to talk about the abuse. It has already been dealt with. With clients who feel this way it is very important that the therapist doesn’t force himself on the client. If the therapist does insist anyway, it is almost never of any help but becomes another victimization on the client.

When these clients are met respectfully it is our experience that they often will work on problems that are more or less directly related to experiences of sexual abuse. Estrangement – dissociation in stressful situations – sexual difficulties, etc.

Clients who seek help to work on sexual abuse

Some clients present themselves as victims of child sexual abuse and that is why they do drugs, binge or have any of a number of different problems. These clients seem to expect and hope that the therapist will help them ‘work through’ their experience or do something that can free them of their problem. They often seem prepared to talk about the abuse.

Sometimes a client comes back to the third or fourth session and tells that the ‘real’ problem is sexual abuse. The client wants, or needs to talk about this to find some peace from it and believes that the addiction problem will be solved in the process.

A client being set to talk about his or her experiences doesn’t automatically mean that the conversation needs to deal with the sexual abuse in itself. We think that it is always wise to start by finding out how the client imagines life will be different, when these previous difficult and painful experiences no longer create problems.

We ask for instance: ”What do you think you will do differently in your life, once you are convinced that your father takes on responsibility for what he did to you?”

Independent of the starting point

Meeting all these clients is always built on finding out their ideas about what their problem is and what their goal is. By talking about this in a traditional solution focused therapy, many clients get the help they want.

After a few sessions it will be clear if solution focused therapy isn’t enough. Maybe the client continues to put himself in dangerous situations because of a strong remaining tendency to dissociate. Maybe the client wants help to reach goals that has to do with a different contact with his family. Maybe the experience and memory is so fogged up that both we and the client agree that the client need to remember at least some to feel and live as a whole person.

Going through completely how to do therapy with clients who were sexually abused is beyond the scope of this book. Only a few points are made here.

When clients start talking about the abuse they often get the desire to confront the perpetrator. ‘Meeting the one who caused so much suffering and put it all back on his lap.’ Some clients choose not to bring it up with their families. They know for certain that they will never get the support they need from their family-members, or they know for certain that the family will join together and reject them. Other clients are prepared to take the risk or they may feel that the mendacity is to high a price to pay, and they are prepared to find supportive networks elsewhere than in the family. Other clients simply feel they have nothing to loose.

It is important for clients to stop feeling guilt and shame and put the responsibility for what happened back onto the perpetrator. Confrontations to early can however do more harm than good. The client needs to feel reasonably strong and certain that she can go through a meeting with the feeling that she will be leaving something behind. The possible outcome of the meeting need to be reviewed in advance and the client needs help to foresee a perpetrator who bluntly denies everything or a mother who says that it was the clients own fault (for instance ”the way you dressed!”)

One way to prepare is for the client to write a letter to the perpetrator, where the client expresses what he or she wants to tell the perpetrator. No matter if the client meets the perpetrator or not, or if the letter is sent or not, it can be an important symbolic gesture – the responsibility is put where it belongs. The next step can be for the client to write the letter she thinks the perpetrator would write as an answer, and yet another step can be for the client to write the letter she would have wanted to receive from the perpetrator. Such letters can also be written to other people in the client’s network.

Other things as important to work with can be strong tendencies to dissociate that can put the client in danger, flashbacks that jeopardize sex, general anxiety and a number of problematic behaviors that clients can develop.

For you who wants to penetrate the subject more thoroughly we recommend "Resolving Sexual Abuse – Solution-focused therapy and Ericksonian hypnosis for adult survivors" by

Yvonne Dolan (1991). This is a book that describes the treatment of adults who were sexually abused as children and it is an endless source of inspiration. [29]

Hopeless cases

By now it's probably obvious that we don't think there is such a thing as a "hopeless case". We see "hopeless cases" as a denomination or metaphor that therapists use when they feel desperate or don't know how to be helpful. Sometimes it's a label a client will use about himself. It's not particularly useful to help oneself or others.

When you think this of a client it is best to let the client see someone else and not say that you think it's a "hopeless case". The most useful way to do the hand-over is to see the client together with the new therapist and tell about all the resources and strengths that you haven't been able to help the client see within himself.

[29] A radically new approach has been described by Allan Wade in Contemporary Family Therapy 19(1) March 1997. It's well worth reading for anyone interested in working with clients who have suffered abuse.

SPECIAL TECHNIQUES

In this chapter we talk about different things that can be called techniques, ideas or special ways. They all have in common that they are useful in many different situations and that creative and curious therapists (those who read this book) can modify them and create many other 'special ways'. The names we have given the different ideas are pretty coincidental and most of them fit under different headlines.

Ceremonies

Ceremonies and rituals are cultural phenomena that mark change. They can be very useful to stress and highlight differences

When clients have done things they didn't think they were capable of doing we try in different ways to help them create meaning around what happened. We clamor "Wow!!! we ask them "How did you DO that?" we say "Congratulations!" etc. All these have in common that they are markings that can create a difference that is a difference. One way to do this even stronger is to make something special – a ceremony – out of the event, either in the therapy-room or in the home.

Party

You make a party to celebrate something; a birthday, a marriage, a house warming party etc. When clients have attained for instance abstinence for a longer time than at any previous occasion this can be something worth celebrating. The hard work it took is acknowledged and may become a difference that is difference.

> Jakob lived in a very close family that loved parties. When Jakob had given his girlfriend all his syringes and she had 'buried' them, the much-impressed therapists suggested the family should throw a 'funeral party'.
>
> As Jakob had started to constructive things for himself the therapists suggested that the theme for the party should be 'For the burial of the kid and for the welcoming of the adult'.
>
> Afterwards they all guaranteed that this was a party they'd never forget.

Diplomas

Diplomas are received when something has been accomplished. Having learnt to drive a car, to swim or having finished training as a therapist.

With us it sometimes happens that both young and old clients receive a diploma when they have struggled with their problems and have made progress in their life.

> Helped by her parents Viktoria has managed with a difficult social situation. Drug abuse, phobias, separation from a drug-abusing husband, two small children.
>
> In the final session the therapist (SE) returns after the break and says: "I have something for you."
>
> "Oh," she says, smiles a little, blushes shyly and says: "Is it a diploma?"

”How did you know?” asks the therapist and hands it over. She doesn’t get any response. Viktoria and her parents read and shine.

Our experience is that it is useful to hand over a diploma in a very solemn way. We usually do it standing. We shake hands. We bow and congratulate and the audience (family, team and network) applauds. Sometimes we bring the whole team in and everyone shakes the client’s hand. The ritual and ceremonial element is important.

Advice to others

For many clients the change from being someone receiving advice to someone giving advice is an important moment.

We explain that we are very impressed by what the client accomplished. We have met and will in the future meet clients with similar problems and we wonder how and what the client did to solve his problem and what kind of advice he or she has to other clients with similar difficulties.

The response is often written down and almost invariably handed back to the client (see for instance Cecile page 111).

Acknowledgement therapy

This is a concept we borrowed from Ben Furman who described it in a book "Lösningar för missbrukare[30]" (1991).

The therapist asks the client to imagine himself a few years into the future. The problems are solved and the client is satisfied with his life. The client is suggested to think that he is throwing a party to which he invites everyone that contributed to the problem being solved. ”Who will you invite and how will you thank each one of them?”

This work is fun, thrilling, creative and much appreciated by clients and therapists alike. It’s always easier to talk about possibilities in the future than problems in the past, as it is easier to tell how you solved the problems when you imagine that they are already solved. Another aspect is that the therapist takes a clear and unambiguous position. The client will use his resources to solve his problem. The question is not if, but how and helped by who.

Milena returns to therapy six months after she terminated a first series of sessions. She feels insecure in her new situation, is doing well in school but she has difficulties to protect herself from her husband and her father. She is also unhappy after a short but intense love affair. She shows rapid progress but in the fourth session MS behind the mirror thinks that nothing much is happening. He suggests HK (therapist in the room) to do ‘acknowledgement therapy’, and HK, who feels insecure about doing this, asks him to come in and do it.

MS asks: ”Suppose that three years have passed, everything is going well and all your problems are solved. You decide to throw a party and you invite everyone that has been important to thank them for what you are and have become. Who do you invite and what do you tell them?”

Milena thinks for a while and starts a little hesitantly: ”I would invite my parents, the two of you and Morgan (her ex-husband).”

”What do you thank them for?”

---

[30] The translation would be something like ”Solutions for addicts”.

”My father I would thank for teaching me to stand on my own.” She hesitates a couple of seconds and then goes on: ”My mother I would thank for giving me self-confidence. Morgan I would thank for teaching me to paint. My son brought sunshine into my life, my social-worker helped me out of the fog, and you two helped me go from words to action.”

”Both the words and actions were your own,” answers the therapists and she smiles proudly.

Expiation-therapy

Father is very disappointed with Torleif. He feels so hurt and so bitter. He can not imagine what could be different that would make him think it would be possible to forgive his son. It’s the last thefts that made it. He had really started to believe that Torleif had changed and *‘had given him everything’.* Now he punishes Torleif all he can *‘to make Torleif feel something of what he feels’.* At the same time he can’t imagine what would be a reasonable punishment. He has thought of the possibility that *‘the cure may be worse than the ill’,* but still can’t change this.

Mother doesn’t know what to do. She finds her husbands position to extreme but she wants *‘to give the children the right signals’* and show them that the parents are collaborating. She is confused but *‘finds some comfort in religion’.*

We talk alone with Torleif about the situation, while the parents wait outside. He is filled with shame and despair over having failed his parent’s confidence. He laments over the fact that no punishment can ever satisfy his parents and hence bring him relief. We explain to him that he has missed the whole point with the punishment. The most important part of a punishment is that *‘it makes the sinner forgive himself’*, and we discuss with him till we find a punishment that would bring relief to his feelings of guilt. Something that would make him feel that he *‘expiated his sin’*. He is immensely relieved after this and says that he never saw it like that, *‘like something he could do for himself’.*

The session is then ended together with the parents. We explain that we understand their dilemma and that they are right in not being able to find any punishment. No one can help anyone else *‘to expiate their sins. Penance is something you do for your own sake.’* The parents nod in confirmation. We explain that we talked to Torleif about this and we have agreed with him that penance is something private. But as we are also social beings it also needs to be public – that penance can be recognized as such for it to work – but yet it is mainly private. We then ask them to pay attention to what they see Torleif do that to them means that he is *‘expiating his sin’.* We point out that it is important that they note for themselves what they see and that they do not discuss it with each other or with him.

They are relieved and smiling when they leave.

Note-therapy

One sometimes talks about the power of the written word and means that that which exists in black and white is more valid than what has only been said. One can also go back to that which is written and read it many times.

People have different ways to remember; some remember best what they see, other remember what is said and some remember best what they have written.

For these reasons ‘notehelp’ is often useful for clients who need to remember important things.

One way we use notes is that the therapist and client writes down important points on a note and the client brings the note home and keeps it in his pocket, his wallet or his dressing table. (Memory-note, message to oneself).

When the client or a family-member doesn't want to discuss or argue about a particular question he can write down what he wants to say on a note. The note is then put in a place where there is a guarantee that it will be seen or given without verbal comments (message to others).

Memory-note to oneself

The health-certificate

Antonia is 18 years old and just out of intensive care after a suicide-attempt. No one considers her hashish-abuse or her eating behavior (anorexia-boulemia) as the real problem. Everyone including her therapist seems influenced by the idea that her problem has 'its roots' in her history of sexual abuse.

For the first quarter of an hour, Antonia's mother and therapist ask her lots and lots of questions but despite apparent efforts on Antonia's part the only answer she can find is: "I don't know."

"How did you do it not to be totally devastated by your terrible experiences?" asks the therapist, but Antonia looks at her helplessly and answers "I don't know." Mother's eyes are watering in face of her daughter's obvious despair and helplessness. The therapist looks increasingly concerned and worried, and so does Antonia.

More attempts with coping-questions don't lead anywhere. In desperation mother cries out: "You have to talk about it Antonia. You have to talk about it!" With increasing desperation Antonia answers: Everyone keeps nagging me about that I have to talk about the abuse, but I don't want to – and I don't need to either." The desperation in the room is felt all the way through the one-way-mirror. Antonia stares on the floor and on the teams request the supervisor (MS) walks into the room.

"When I sit and listen to you talking I get two ideas that I would like to share with you Antonia." Antonia is still staring on the floor. "I start thinking about these glass-doors they have in big ware-houses. If they are well polished there is a risk that you walk right into them. I think you have put up such doors around you to show your limits and boundaries. I think it's good you did that. That is healthy." Antonia looks up and looks him in the eyes. "I see your mother and your therapist really trying very hard to help you, but unfortunately they walk straight into the glass-door as it is so well polished." Mother nods confirmingly towards MS while Antonia holds his gaze and maybe nods ever so little. MS continues: "My other idea is that I would like to write you a health-certificate. A health-certificate because you learnt to protect yourself and show in a clear and healthy way what you want and don't want – and because you know what you need."

It's mother who reacts: "It's so good to hear you say this. So good. It's like a stone falling from my chest," and she lifts her hands to her breasts. Antonia looks at her wide-eyed and slowly tears fill her eyes. Mother opens her arms and mother and daughter hug in tears.

The therapist and the supervisor take a break and leaves mother and daughter by themselves. They return together to the therapy-room and say:

"We decided to write a health-certificate. Here you are." Antonia takes it and reads carefully. It says: *"Hereby it is certified that you, Antonia, is not half as sick as other think you are."* When setting up the next appointment with the therapist she says:

"This was the best that ever happened to me. I'll put this in my *'important-folder'* and when things are really bad I'll take it out and look at it.

When she returns two weeks later she says she feels good. She has looked at the certificate a couple of times. She has also been able to 'keep her limits' in several new situations and mother agrees with her that they don't have to come back before two months.

The tricklist

It was incomprehensible to Donald (page 88) how he had succeeded to do the 11 things on the 'tricklist' that helped resist the urge to use gas. When he had 7 items on the list he took the list

home, but it was first when he came up to 15 that it was clear to him that he himself had control over what he chose – gas or trick.

Advice to others – and oneself

The therapist (MS) asks Cecile in the fourth session: ”I meet other girls and boys in similar situations, who are struggling with their problems. What advice would you like to give them?”

She thinks for a long while and then responds: ”1. Live normally, do what you normally do and don’t lock yourself in. 2. Seek those who support you. 3. Go away from those who pity you.”

MS writes her answers down and she brings the note home with her.

A month later she is raped and gets seriously depressed. She locks herself into her apartment and goes to bed. On her dressing table is the note with advice to others. After 48 hours she sees the note and reads it. She decides to follow her own advice and gets up. The same day she contacts her friends and the police.

Notes as messages to others

Today’s figure

Bernadette’s parents can see that she is improving, but their worry won’t pass.

”If 10 means that you are entirely ok and 0 the contrary, where are you at today?” asks the therapist (MS). ”6-7” answers she.

”Where on the scale is there a risk for relapse?”

”When I’m at 5.5 it starts getting difficult,” answers Bernadette and the parents look even more concerned.

In the summary of the session the therapist suggests that Bernadette should put up ‘today’s figure’ on the door of the refrigerator. The parents then only need to be worried if the figure falls below 6.

During 2 weeks the parents pull a sigh of relief every morning as they see figures that are 6 and higher.

Today’s poem

In the example page 39 there is an example of the use of notes.

Leonardo’s father was encouraged to experiment with communicating by notes instead of talking, to see what difference this made. He prolonged the idea by himself and put a poem for Leonardo on the mirror in the bathroom. Three weeks after he got a long longed for appreciating comment from his son.

Praise-tickets

”When I want to tell him something he did well, I write it on a piece of paper and hand it over to him. It becomes a little special then”. The therapist and the mother smile together.

CONSULTATIONS

Generally

The purpose of consultation varies. We have the habit of consulting on each others cases when we feel we've run out of ideas or when we think that what we are doing is of no help to the family and there is a need for new and different views.

When you've worked for a while in a team, helping clients to construct solutions, and you have become more skillful at this, you will also gradually become more hopeful about the possibilities to find solutions to even apparently impossible situations. You will then soon start asking your colleagues to do consultations on your 'stuck' cases and you will be asked to consult to your colleagues on theirs.

It is also common that consultations are used in the context of training. The purpose is then two-folded. Besides helping the family a training-group trains to work as a team.

When we do supervision it is common that a therapist brings up difficulties he has in relation to some family-member. Most difficulties of this kind can be solved in supervision but occasionally it can be helpful when an "outsider" does the interview with the family and the therapist. This will often give the therapist a completely new understanding of the situation.

Paradoxically consultation-interviews are much easier than most people believe. The expectations on the consultant doing the interview are high both from the therapist and the family. The therapist asking for consultation often does it in a situation, and with families, where there has been therapeutic progress and surprisingly often the family and/ or the client have done much more progress than the therapist is aware of.

We usually want the therapist to be present in the session with the family or the client. The advantage is that we can ask the therapist to comment directly on the progress the family describes and also work with connecting this progress to the work the therapist did. We think this is important so we don't make it harder for the therapist to continue his work with the family afterwards.

It is often a good start to find out how far the family has come and what the therapist has done that has been useful for the family. Use scaling-questions and ask the family to describe what the therapist has done that has been of help, and also ask the therapist to describe how he sees the family, especially if there has been progress and the family has complimented the therapist a lot. Start as always though by clarifying the context:

"I have been asked by NN to meet with you to help you do an evaluation of your contact/ treatment"

Another way is the consultant asking the therapist, the social worker or whoever is working with the family to tell the reason for the interview.

When it comes to the goal of the interview useful questions are amongst others:

"Imagine this will be a very good meeting that is useful for you, what have we come up with then?"

"On a scale from 0 to 10 where 0 means the worst situation you have ever been in and 10 means the problems are completely solved - where are you today"

You can ask the therapist:

"How far do you think Nisse has come on the same scale?"

"What would be a sign that Nisse is one step higher on the scale?"

"When is the time to end therapy?"

When doing consultation-interviews it is important to remember that the consultant isn't supposed to take over the therapy. Instead he is supposed to do an interview based on the context and the goal the therapist and the client have defined.

The couple, the therapist & the miracle

Jim has been sentenced to 75 hours of therapy for the second time. The therapist, Mike Weuste, Elmhurst Hospital, Chicago has met him for a couple of sessions alone and has also had some sessions with Jim together with his wife Dora. Mike thinks the couple is very nice and he enjoys meeting them but he wants a consultation. To Mike it seems that Jim just sits the time off and Mike hasn't got a clue to what to do with the remaining 65 hours or so.

The consultation-interview was made by Martin Söderquist. Harry Korman, Jocelyne Lopez-Korman and Kristina Engman were the team behind the one-way mirror.

MS: My name is Martin

Dora and Jim: Hi

MS: I work as a family therapist in Sweden and we are here doing consultations. I am not alone, we seldom or never work alone meeting couples or families so I have a team behind the screen (MS points and Dora waves her hand). In fact three other therapists and they might buzz the telephone and Mike and I might take a break to discuss with the team. Mike has asked me to do a consultation and in some way evaluate how far you have come in your therapy. Let me ask you the first question. If 0 is the worst situation you ever been in, that is 0. 10 means the day after the miracle, the problems are totally gone and wont come back, that is 10. Where are you today?

Jim: 5

Dora: That is what I was thinking. Probably 5, maybe 6.

MS: Maybe even 6!

Dora: 5,5.

MS: When you started seeing Mike, if I had put you the same question then. . .

Dora: 2.

MS: Then you were on a 2?

Jim: Probably me too.

MS: So you have gone from 2 to 5-6 in how long time? Mike said something about 4 or 5 sessions.

Dora and Jim: A couple of months.

MS: How did you do that?

Jim: Worked I guess.

MS: You worked?

Jim: Working on it.

MS: What did you do?

Jim: We started talking a little bit more about what worried us.

MS: You talked. How did you manage?

Jim: (inaudible - everyone laughs)

MS: If I had asked Dora what do you think she would have answered you had done?

Jim: I donut know.
MS: Guess!
Jim: Talking to her, not being as crabby.
MS: What is crabby?
Jim: Not being upset or yelling at her.
MS: OK.
MS: (to D.)How did you manage to go from 2 to 5,5?
Dora: I donut know . . . . not being as demanding, trying to be a little, you know and not " Jim, Jim, Jim . . "
MS: Not so pushy?
Dora: Yeah, not so pushy.
Mike: How did you decide to do that?
Dora: Not push him to talk, not push him . . sure once in a while I push a bit. I try to think more how I feel about myself and if I have a statement to make to him I'll do that. But I'm not going at him hysterically, you know. Instead I go to him and say I really don't like when you do this. Before I was shouting and was upset.
MS: How did you decide not to do it that way?
Dora: My mother gave me some tapes and the tapes were " The dance of anger".
Dora: (to Mike) You are familiar with them?
Mike nods.
Dora: They have a book out and it's about women controlling their anger. Instead of coming out hysterically talking to their spouse - coming out stating something and just leaving it there. Letting him know about it made me feel better. Before I would still be upset after I would tell him what I want because it would come out all . .
MS: What more did help you to make your decision? The tapes, are there other things too?
Dora: Probably everything, the tapes, realizing we had differences and that we had to go to counseling and being in counseling - knowing we are in counseling together and we are trying.
MS: What is the best help Mike has given you? What is his best advice to you?
Probably not to push Jim about communicating, that's one good thing. It really made me think - because I'll always push, push. I want to talk, I want to talk. I always thought about myself, I never thought about him. maybe I should sit down and think why doesn't he want to talk.
MS: Mike didn't push Jim either?
Dora: I don't know.
MS: What do you think Jim, what is the best Mike has done to help you?
Jim: He has given us suggestions. trying to spend some more time together.
Dora: Yeah that's another one he gave, a real good one.
Jim: It didn't seem to work all the time.
MS: But it was a good suggestion?
Jim: Yeah.
MS: And it did work out sometime?
Jim: Yeah.
Dora: Just to plan a night together me and him even if it was only an hour a week. Just to talk or something like that.
MS: How much have you done that?
Jim and Dora: To tell you the truth.
Jim: Not too much .
Dora: We've done it occasionally but ....
MS: When was the last time?
Dora: A while back.
MS: Do you remember the occasion? What did you do?

Dora: Last time I remember we went out together him and me, we went out shopping. (to Jim.): remember?
Jim: Yeah. A Tupperwareparty too.
Dora: That's true (laughs).
MS: I didn't quite follow?
Dora: He got (inaudible) . . taking me to a Tupperwareparty.
MS: A Tupperwareparty!!
Jim: A bunch of women.
MS: That was OK??
Jim: (Nods).
Dora: He would never do stuff like that before. He would never sacrifice. I couldn't believe it.
MS: He really astonished you?
Dora: O Yeah. In that way - that's what I've seen different, like when you asked me . . I've seen him more compassionate, like Jim for instance. I was in an accident so he told our son to move to sit somewhere else and let me sit on the chair because my neck probably hurt. Stuff like that he would never do before.
MS: Has he given you more surprises?
Dora: He has given me flowers.
MS: Is that also a thing he wouldn't have done some months ago?
Dora: Yeah, he supports me.
MS: How does he support you?
Dora: Just talks to me and tells me a tiny bit of his opinion. He won't go in to detail in the conversation - I want to talk and talk.
MS: Has she astonished you, given you surprises too?
Jim: Yeah, she doesn't jump so much as she used to, arguing. . .
MS: Why do you think?
Jim: Why. I don't know. She wants thing to work out better. She went with me playing cards the other night.
MS: She . .?
Dora: We were supposed to go somewhere.
MS: And?
Jim: She went with me to my friends.
MS: That surprised you?
Jim: Yeah, that was a big surprise (All laugh).
Jim: (inaudible).
MS: Has Mike given you more suggestions that were quite good, the second best suggestion what was that?
Jim and Dora think for a while.
Dora: I kind of liked that circle suggestion. Remember I said I wanted to write things that we liked by each other, things that aggravated us and we try to change. Do more of the things we liked and less of the things that aggravated us. Write them down. And you (to Mike) made a suggestion about something I can't remember . . what was that Jim?
Jim: Role reversal.
Mike: What??
Jim: Role reversal.
Dora: He wants to do that.
MS: Did you do it?
Jim: Not yet . . . but one of these days.
Dora: He wants to do that, it's OK as long as it is on a day when the house is not too clean - he can do it all.
MS: So you have to do a little more planning?
Dora: Probably yeah.
MS (to Dora): What would it take to go from 5,5 to 6,3? What would have to happen?

Dora: I think the compassion has to stay there, I really do. It has to stay, it can’t just stay and go for a week.
MS: More stable?
Dora: Yeah.
MS: How . . .What is the first sign you can see that convinces you that it is a little bit more stable than before? What is the first sign?
Dora: Ah?
MS: That moves you up the scale?
Dora: I don’t know.
MS: What is the first sign you notice that makes you go from 5,5 to 6,3 ?
Dora: That it is constant, that it is not up and down. Not one day compassion and understanding and the other day ... .
MS: How do you notice?
Dora: I can tell, because he criticizes (inaudible).
MS: So he is not doing that, doing other things instead - as for example?
Dora: " Do you want a sandwich, I’ll make you one ". That was great.
MS: He did something for you?
Dora: Yeah. Maybe a suggestion or something. " Do you want?" " Shall we watch this or what do you want to watch ?"
The telephone buzzes.
MS (to Jim): What would have to happen for you or what will you notice that make you go from 5 to 5,8? What would be the first sign?
Jim: For me?
MS: Yeah, the first sign you notice.
Jim (looks at Dora): More understanding and not being so crabby.
MS: And doing what instead?
Jim: (inaudible) . . not jump right away before she thinks about it.
MS: And when she is not doing that and doing other things instead what would be the other things?
Jim: Keep the house all clean I’ve understood lately. We’ve been through a lot. . .
MS: You have ! You have a little kid too!
Dora: Yeah, he is 6 and we have one on the way too.
MS: How far has he come?
Dora: It’ll take some months. He is only 1,5 months.
MS: So it’ll take some months.
Dora: Yeah.
MS: You said ....?
Jim: I’m not a perfectionist wanting everything clean at home.
Dora: He doesn’t like to live in a house that’s gotta be picture-perfect
Dora and Jim: (inaudible).
MS: What do you think Mike needs to see? What will he notice as the first sign of you going higher up to 5,8 and 6,3 ? How do you think Mike will notice?
Dora: If we talk about one subject.
MS: For a whole hour?
Dora and Jim: For a while at least.
Dora: I think he will notice progress in communication.
MS: If it is progress in communication between you - how will Mike notice that ?
Jim: Probably that we will talk about the same thing for a while.
MS: What do you think Mike will tell you then?
Dora: That’s great!
MS: What do you think, Mike, you will notice as the first sign of more progression? Is it called that?
Dora and Jim: Yeah.

Mike: Both of you talking about feeling satisfied, with continuing to do these things you say are right. More stability and you are doing what works more.
MS: Suppose, Mike, they won't tell you - how will you notice "We don't tell Mike this time and see if he notices". How will you notice if they don't tell you?
Mike : I don't know.
MS: Can you see it?
Mike: I think how they kind of come off being closer to each other.
MS: How?
Mike: The closer they sit. How you guys look at each other. I think you can sense respect towards each other more. I think in terms of how you talk. It's much more of these things I see you do that are good for you and I appreciate what is going on - I think both of you are feeling more close.
MS: I have another question. Suppose that a miracle . . . You go home, sleep tonight and when you wake up tomorrow a miracle has happened - all your problems, whatever your problems have been or are, they have gone, disappeared. How will you notice that when you wake up tomorrow?
Jim: Winning a Lottoticket. That would help.
MS: I understand. How will you notice that tomorrow morning when you wake up and when will you notice that your problems are gone totally
Jim: (inaudible).
MS: OK - more or less gone. All the main problems are gone.
Dora: I would notice that we were friends and we talked and how we got up making breakfast, you know -doing things like being nice to each other and a couple of other things, I'm sure.
MS: Like what?
Jim: When we first met.
MS: Like when you first met?
Dora: Just a sense of happiness, being close, being with each other instead of always being unstable knowing that it is stable now. I'm sure we are going to have a little bit of rockiness but at least you have it under control knowing that you have a stable relationship.
MS: Tell me more about when you first met? Then you didn't have your problems.
Jim: We have been together so long, for so many years too - it would be like getting to know each other again.
MS: How was that getting to know each other?
Dora and Jim look at each other.
MS: What did you appreciate most with Dora?
Jim: I can always find out more about her though I have lived with her and know everything about her.
Dora: You don't. You think you do.
MS: (to D.) He doesn't know you.
Jim: I know her more now - I know her faults now.
Dora: But if I surprise you, it means you don't know me as much about me as you think.
MS: You have surprised . . .
Dora: Same with me. You have surprised me. It means I don't know you as well as I thought I did.
Jim: (inaudible)
MS: You are older now, you have a kid . .
Jim: Sober now too.
MS: And you are sober.
Jim: It's 10 years of my life using drugs and stuffs. I have to start dealing with things all over again, things I haven't done before. It's different.
MS: For how long time have you done it without stuffs?
Jim: 7 or 8 months now.
Dora: It means drinking too.
MS: (to Dora) What did you appreciate then ?

Dora: I liked the way he was considerate. The way he were . . If I wanted something - for instance if we were driving and I was hungry, he would stop at a restaurant. Considerate, respecting me, listening to me, not ignoring me, asking me what I wanted to do. You know what I mean?
The compassion was there.

MS: How likely is that to happen again? Are you able to reach 10?

Jim: I think so.

Telephone from the team.

MS: The team are phoning to say I am in a little bit of hurry now. I didn’t ask that question before the telephone call, you haven’t heard that question. They wanted me to ask you: Has it already happened? Have you had a time last week or some weeks ago that was a kind of experience you remember when you were newly engaged?

Dora: Something that was; "Gosh, that was something like it was 10 years ago"?

Jim: I suppose it has been a few times.

MS: It has! Good!

Jim: (inaudible) . . Sunday eating breakfast . .

Dora: (inaudible).

MS: So you have had some experiences not long ago of this kind ?

Dora: Yes.

MS: How likely is it there are more situations like this coming - more and more often. ? How likely on a scale from 1 to 10? 10 is you are quite sure it is gonna happen?

Dora: I think it would be a 10 as long as we both try. I think, you know what I mean. there is no doubt about it, cause if we try there is no ... reason to even think it would be a 2 or 3. You know what I mean. Because we have come as far and we are still together, we’ve been through a lot.

MS: Yes, you have.

Dora: If the compassion is there and you know it is there - it’s just a matter of yourself, like say for me - it’s a matter for me not jumping like what he said. Stopping myself before I do it and if I know . . . and it would be a matter of me being compassionate knowing, just knowing that’s what I want: I’d rather be nice than being crabby and mean - trying to stop myself.

MS: I’m a fan of scales as you have noticed. If 0 means that you are not going to do a single shit to make anything good and 10 means that you are prepared to do anything to get this going in a smooth and fine way as you want it. Where are you on that scale? Just right now.

Dora: Say 8, cause I try but I’m sure I don’t try hard enough.

MS: Sounds reasonable. Where are you Jim on that scale ?

Jim: About 6. Caring more about myself more than I do for her.

MS: But you are on a 6. It’s between 5 and 10. You have past the middle of the scale.

MS: (to Mike) How likely do you think it is that they reach their goals?

Mike: How likely on a scale 0 - 10?

MS: Yes

Mike: I think for these guys about a 9.

MS: So you are pretty confident they are going to make it. Why are you that confident ?

Mike: Because they, sort of the way they are saying. They have been through a lot together, they have a lot of willpower to make this thing work, you are more motivated than a lot of couples I’ve seen. And you really come in here every time I see you saying "We want this to be different" You are not exactly sure all the time how to do, but I see in both of you the same amount of willpower to make this work that it took for both of you to get sober. I mean you guys have made some significant decisions that you want to have a healthy, good family that is pleasing to both of you, that you feel comfortable in and you are very committed to that. You come back here all the time to work at that. You work at it on your own, you are very motivated away from here and you show a lot more motivation than a lot of couples I se. I put you way up on a 9.

Dora: That's what I meant when I said trying. I couldn't see . . I didn't kind of understand what you were saying when you said from 1 to 10. . . . . I don't know what the question was?
MS: How likely it was - that question?
Dora: For the compassion to continue. That's what I meant by what you just said. willpower and knowing that you can be compassionate.
MS: You know that you can.
Dora: Or you can be not as snappy at a person. If you think and trying to stop yourself before you are doing it. I think probably try all the time but something you find yourself being crabby but then I just want to apologize and say " I'm really sorry, you know I'm just a crab - let me go to sleep. It's not anything you said, it's just me. I'm the crab".
MS: What's the name of your son?
Dora and Jim: Jim junior.
MS: If he had been here . . .
Telephone call - the team want the therapist to focus back to the miracle question. The therapist wants to continue talking about the couple's son.
MS: They wanted me to for a little while go back to the miracle question. You said that if there was a miracle tonight then you would notice you were more talkative and a little bit more compassionate. How would your son notice that tomorrow morning when he woke up ? How will he notice: " A miracle has happened". I don't know if he knows what a miracle is but suppose he knows that. What will he notice?
Jim: He wouldn't see us yelling or arguing
MS: What would he notice you doing ?
Dora: I think. Maybe he notice me being more relaxed.
MS: How would he notice that?
Dora: He would notice because, he just . . . When I'm crabby or if I'm aggravated for say I try not to take it out on other people . . . . I don't really scream . . . . Probably he could ask me something four times and I would still be nice, probably if he asked me the same thing four times - I would probably still have the same nice tone of voice. That's probably what he would notice.
MS: What would he notice of Jim senior?
Dora: What I think he'd notice ? That if he asked him a question, Jim would turn around and completely give him an explanation.
MS: How would you notice that Jim junior has noticed?
Dora: He was calmer.
MS: Calmer . . .in what way ?
Dora: Some days he can sit like us and he would be calm, he would talk to me, sit there and talk about anything. Then he has his days like what I said. he would ask " Call one, call one, call one " He'd ask me something five times and my answer will be no and he will continue to ask me this. So he has done two days. He will be a little bit more calmer.
MS (to Jim): How will you notice Jim junior has noticed ?
Jim: He will calm down a bit and not being so pushy.
MS: And what would he do instead, playing with toys or doing things on his own?
Jim: Probably doing things on his own.
MS: If he did that - what would you think then?
Jim: A miracle has happened.
Dora: Yeah, that sure would be - a whole week of that (all laughs).
MS: What changes have you noticed on Jim junior these last months ?
Dora: Go ahead Jim.
Jim: He has . . . (inaudible) and that was a surprise.
MS: So he has surprised you too and you have surprised each other.
Dora and Jim: Yeah.

Dora: Before he was everyday always crabby and just frustrated but then it tended to get . . .some of the days he'd be able to sit like us, we could do a craft and that gave him a sense of family and he likes it a lot.

Jim: He is like that he wants it he wants it now.

Dora: It's both of us. That's me too.

MS: He is a little kid, he is 6 . .

Dora: Of course. He wants to stay up to midnight and be outside in the summer. He'd be out there till he falls asleep. I got to expect stuff like that. - Sometimes I forget he is only 6 . .

MS: Do you have any . . . I usually . . .

Telephone call

MS: They have a question. Do you have any question before the break ? . . . . They have one more question. What did you guys do to make this miracle happen? Cause it sounds like some of it already happened.

Jim: Lot of it has to do with quitting drugs and drinking and stuff - that's the primary thing. The program teaches you to deal with things that pushes you and try to deal with changing yourself instead of changing other people.

MS: That really helped you!

Dora: What was the question?

MS: What did you do to make this miracle happen ? Because some of the miracle has already happened.

Dora: For me it was that I knew I loved him a lot and that we either had to get help or we would probably not be together. I think that is what it was for me.

MS: It was that desperate?

Dora: Yeah. We go out and drink and drink and you know . . . I know that's a way of relief and you don't talk about your problems if you drink.

MS: I'll take a break and discuss with my team. Do you mind sitting out in the waiting room ?

Dora and Jim: Not at all

The break lasts for 20 minutes.

Intervention:

MS: We usually do like this and I have written everything up that I want you to hear from Mike, me and the team. To begin with: We are very impressed by your way of describing the good things that has happened. I said that the miracle has already happened, partly at least. And your way of describing the goals, what you want to achieve. you have been very specific about describing those things, so you have helped us a lot with that to understand you.

We are very impressed by you Jim. You are very mature, you have been through a lot of things, I understand and I think you have learned a lot by what you have come through. You have a lot of wisdom in all these experiences you can use and you are using it. Mike said in our discussion that you seem to be more mature than a 25-year old, you are more like 30 -35 in your way of thinking and doing things.

We are also very impressed by you Dora. One of the team members said that you are a bright lady who knows a lot about marriage and one who works a lot and do much to make it a good marriage. You are very good in observing, articulating and expressing. You are very good at that especially the observing part. We are very impressed by that.

We really think you are on the right track. You have done a lot, you have created your miracle and you are on the way to go on with that. We totally agree with Mike that you are on a 9. We really think you are gonna make it.

We have a suggestion, a kind of homework. A recipe - it's not a medical thing but this is another kind of recipe, more of a homework-recipe. We suggest that you surprise each other once a week and don't tell each other that you are going to surprise - which day and with what. Don't say anything - just surprise each other with small things and don't tell each other. Keep it a little secret and notice what the other do and how the other react when you

surprise him or her. Keep track of it in a notebook or something and discuss it with Mike next time you see him.

Mike: Part of this is that you don't tell the other person when you did the surprise either

MS: If he or she didn't notice . . .

Mike: Right - and when you come back here we're gonna go over the notebooks . . .
Is that right ?

MS: Yeah.

Dora: Thank you.

MS: It was nice meeting you. Good luck !

One year later MS calls Mike who tells that Jim and Dora are very well together, have one more child and enjoy being parents to two children. Mike still sees them occasionally.

TERMINATION

Generalities

Some clients are very clear about when they want to stop therapy even if everyone is not as direct as little Lisa:

> Lisa is 7 years and has been sexually abused. She has been in therapy for a long time without any clear improvement of symptoms that we don’t know very much about and eventually comes to MS.
>
> She improves already after the first session and on the way to MS for the second session she turns to her foster-mother and says: ”Mom, how long do we have to continue to see Martin? Is it till I think I’m OK, or is it till he thinks I’m OK?”
>
> Her foster-mother answers that she doesn’t know and that they will have to ask Martin. They ask the question together and Martin looks very seriously at Lisa and assures her that it is when she feels that she is OK. She looks very relieved.

People stop going to therapy for different reasons. They can be satisfied with what they have achieved or they may feel that they can handle the rest themselves. They may also be dissatisfied with what they’ve got and they may have come to the conclusion that further sessions wont make any difference.

In a goal-oriented therapy form where the number of sessions is around 5 to 10, termination is of course very different than in a therapy-form where the number of sessions is higher and the focus is different. The therapist will not become as emotionally important and the therapy will not become as important in the client’s life.

This doesn’t mean that the therapist is not an important person for the client, but as the therapy is short and goal-oriented and both client and therapist have an idea about the goal, termination will be present from the start.

> Mireille is 13 years old when she goes to the police because she can no longer bear that her father is having sex with her. The police doesn’t believe in her and nor does her mother. She then runs away from home and quickly establishes herself as a heroin addict. At 18 she marries and together with her husband she explores the world and different ways to support herself and her habit for 9 years.
>
> She then becomes pregnant. She almost stops abusing – though not entirely – and gives birth to a healthy girl.
>
> A nurse starts worrying about the child who lives with a father who is surely doing drugs and a mother who probably is, and establishes a supportive contact with Mireille. Together with the nurse Mireille opens up, tells about her former addiction, her decision not to start doing drugs again and the difficulties with her husband whom she feels resembles more and more to her father.
>
> She gets a lot of support and finally sets an ultimatum for her husband: ”Either you stop doing drugs entirely and contribute to supporting the family, or I will leave you.” He accepts, says ”Trust me,” and she starts waiting.
>
> One year later there has been no change and the nurse refers the couple for therapy.

Mireille is prepared to do anything to improve the relationship. She wants to be able to enjoy sex. She never did as she starts thinking about her dad every time she has sex. She also wants Malte to stop doing drugs, get a decent job, and contribute to supporting the family.

Your petty jobs are not enough to support us," she says, "you work to little and you have to get work at least half-time besides the other stuff you're doing."

He explains that it is impossible for him, that it will be all right and that he will quit doing drugs: "Trust me."

In the eight session we[31] ask Mireille what she got out of therapy. She answers: "You've helped me do what I had to do," and on the following question: "On a scale from 1 to 10, how confident are you that you can do the rest without any further help from us?" she answers: "Seven, but I want to continue to come."

The therapist then asks: "how high do you wish to be on confidence before you stop coming here, and what would be something you did that would increase your confidence in yourself?"

She answers that she would leave Malte, and that the first step in this direction would be to start looking for a new apartment.

When she returns after a month she has found an apartment, signed up for a school, found a day-care center for her child and she thinks she doesn't need more therapy. The therapists agree on this and they also agree with her that it will not be easy to leave Malte, and that it will certainly be a painful process. The therapists also agree with her that she will be able to handle it, and she is of course welcome back IF she feels that they can be of help.

Termination is brought into therapy from its start and is connected to the idea that the client will end therapy when he has reached his goals. We usually ask:

"How will we know when we can finish our contact?" or

"If you don't tell me anything about it, how will I know when you have reached what you want from therapy?"

Other alternatives are the future-questions mentioned earlier:

"Imagine three years into the future and we meet again by coincidence. I ask you how you are and you answer that all is well and that you are satisfied with you life – how did it happen, what did you do and how did you do it?"

"When we meet in a couple of years and all is well, you tell me that you have been thinking of writing a book and in that thank everyone who helped you – what do you call the book and what does it contain?"

When you work goal-oriented and solution focused one of your first priorities is to establish useful goals. One of the most important criteria (the most important) for what is a useful goal is that you and/or the client knows when it is accomplished. When you and your clients are clear about this it will be obvious to end treatment when the goal is reached.

Hence we therefor always examine three questions:

- Is it better or is it different?
- Is it in the direction of the goals?
- Is it enough

  if it isn't enough: What else needs to happen?

This leads on to a few simple categories of 'ending'-situations:

- The goals are reached
- No change

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[31] Harry Korman was the therapist in the room. Martin Söderquist was behind the one-way screen.

- The goals are partly reached
- The clients stops coming (no-show)

The goals are reached

When the goals are clear and concrete and the client and the therapist agree that the client reached his goals, it is easy to decide jointly to terminate treatment. The flow leading to this decision is described in another chapter" (page 85 ff.). These terminations are uncomplicated and evident to everyone and always include the option of returning for more sessions if necessary.

No change

The family wants to terminate

Going to therapy is not exactly like going to a solarium. There is no guarantee that therapy will make any difference. When clients and families reach the conclusion that the therapeutic conversations were of no help and probably won’t be in the future neither, it is obvious they will want to quit.

When clients bring this up with us – some don’t and just don’t show up – we express clearly that we see the lack of success as a result of our inability, or as an expression of us having missed something important, and we express regret over this as clearly as we can.

As mentioned earlier we see lack of success as an expression of our inadequacy, while we see success as a result of the competence of the client and family.

The therapist wants to stop

Relatives may want to continue in therapy even if it is evident to you – and probably to them – that therapy doesn’t help them change the situation nor for themselves, nor for their abusing relative.

It’s not easy to stop seeing people who wants to continue to come and who may feel that you are the only one who ever understood how they felt. These endings are often very painful for everyone involved, but may sometimes paradoxically seem to become the starting point for change.

> Ansgar is 55 and very successful in his work. For 15 years he has – accompanied by continuos guilt-feelings – contributed financially to his sons heroin abuse in a desperate attempt to keep him alive. He has been in therapy for two years without success, to try and find other and more useful ways to help his son. During this time he doesn’t succeed even once to bring his son to a session.
>
> After two consultation interviews with another therapist (HK) the team reaches the conclusion that they are of no help. The only ideas available are such that both Ansgar and the team know they are impossible to use. In a very difficult session the therapists puts this to Ansgar and also says:
>
> ”For us to believe that we are of any help we need to see your son.” The issue has been raised many times before and Ansgar has tried many times to bring him in. Everyone knows the team’s request is unreasonable and impossible. Ansgar rises staggering and says: ”If I don’t have you anymore, there is no need in continuing...”

”We can’t do anything for your son without seeing him,” repeats the therapist, ”we have tried for two years without any success what so ever”, and Ansgar leaves. A couple of weeks later he tries on the phone to get a new appointment, but the team maintains its standpoint.

Eight months later he calls in desperation and makes a new appointment. In the session he recounts that it has been a difficult time. Shortly after the session eight months earlier Ansgar went into a relationship with a woman for the first time in 15 years. The son had a difficult time – maybe because of this – and tried to detoxify twice under great drama and turbulence. After the second he was abstinent for four months, but has now relapsed since two weeks.

It is important that you let people measure their own success, and that you do it very often in the therapy. Sometimes you and the family will come to the conclusion that therapy is not helpful and it is then wise to reflect on if you should tell them:

”I think these sessions are not helpful to you, and it may even be so that they prevent you from doing what you need to do.”

Goals partly reached

Doubting clients

Many clients express doubt about being in therapy. Some express that they came because their wife told them to, and they are not at all happy about being with us. They may express clearly that they have come just this once, and they are very clear about their intention of not returning for any more sessions.

These clients and family members sometimes explain that they think that one should handle this kind of problem by oneself, or they may express that they have already come so far that they do not need any help.

Handle the rest oneself

Another group of clients is those who make small, but in their view significant progress and immediately wants to terminate ”and do the rest themselves”. These clients are glad to talk about the progress they have made, but are not entirely willing to speculate over the next step. The situation often becomes clear when the therapist uses scaling-questions. It then becomes apparent that the client is satisfied and doesn’t think he needs to come back.

What we think in these situations is unimportant as long as no third part is in danger. It’s impossible to help people with things they don’t want help with. Any attempt in such a direction will reduce the chances that the client returns for help with another step at a later moment. Besides most people don’t seem to need our help to continue a change process on their own.

Unclear therapists

It happens that clients/families stay in therapy in order not to disappoint the therapist. As the therapist haven’t said anything about terminating the client continues to come.

Sometimes the client continues because he has hope for more improvement (see for instance Carolin page 88). This however happens more and more rarely as we get more skilled in finding out how the client sees his own progress.

When we sense that the client is hesitating to return, we often end the summary of the session with:

”...and we are not certain you need to come back. What do you think?” The answer is often:

”Well, maybe one more time,” and we then offer an appointment a little further into the future and adding;

”...This is an appointment for you to cancel if you don’t need it”.

It is very common for us to receive cancellations for such appointments. Sometimes we feel a little bit more bold and we then say; ”...it’s an appointment for them to cancel *when* they have reached the conclusion they wont need it.”

It is not always though that clients express clearly that they want to terminate therapy.

Failure to attend

Sometimes client and families express their wish to terminate by forgetting to come. Of course this doesn’t mean that all clients who fail to attend wants to terminate.

We always assume that clients have good reason for not attending. Children and relatives may have fallen sick, the client may have been run over by a bus or anything of a million things can happen.

Things may also have improved so much that the client no longer wants or needs any more treatment. It is then of course a sign of health that we have been forgotten.

> Insoo Kim Berg recounts that Oliver 30 years old, failed to attend the fourth session. He had a history of at least 15 years of poly-drug abuse and several years of homelessness. By the third session there had been some very minimal change like for instance Oliver having been able to postpone his morning-dose till 11 o’clock.
>
> One month later Insoo met him in a treatment institution for addicts where he worked as a janitor. He took her aside and explained he didn’t come back because he ”decided to do it by himself”. One year later he was an active partner in a self-help-program for the homeless.

This and similar – though less dramatic – cases from our own experience has made us increasingly respectful for this way of terminating therapy. Gradually we have become less active in re-recruiting clients who miss their appointments.

Ceremonies

We have written about ceremonies in the chapter ”Special techniques”. Almost everything we have talked about there is useful to mark termination and celebrate it.

A health certificate, a diploma or a party can become a memory or a thing that may help to remember in the future what the client has accomplished and remind him of his resources when difficulties arise.

FROM CLEVER SHRUDENESS TO CONSTRUCTIVE CO-OPERATION?

The heroin program

In 1983 we (the authors) read a series of articles and books on family therapy with addicts. We were particularly impressed by the work of Stanton and Todd who made a prospective randomized family therapy study on heroin addicts in Philadelphia 1974-1978. In their research they showed that structural/strategic family therapy with the addict and his family of origin was a very effective method.

At the time one of us considered himself to be a structural family therapist and the other considered himself a strategic and we had recently begun a fruitful collaboration. Stanton and Todd worked with a method they called structural/strategic and we decided to test if it was possible to treat heroin addicts in Sweden with this method. From the autumn of 1983 till summer 1984 we made a pilot-study where we treated 6 heroin addicts in five families with structural/strategic family therapy.

The experiences we made in the pilot-study fitted well with what we had read in the literature. Enmeshed families, bizarre dysfunctional patterns of interaction, inverted hierarchies, extremely close contact with one of the parents, many other addicts in the families, special mythology around death, the problem of addiction fills a function in the family, the addict sacrifices himself for his relatives, pseudo-individuation, pseudo-sexuality, when the addict stops doing drugs someone else gets ill or the parents threaten separation etc.

The pilot-study lead to a larger study; ”Family therapy with heroin addicts – an effect- and process-study” (or ”The heroin-program”), financed by the Social Research Delegation, The Swedish board of health and the commune of Malmö. This study was done at the clinic of Child and Adolescent Psychiatry at Malmö General Hospital during the years 1986-1990.

In the heroin program eight therapists worked together 10 hours a week. Four were relatively experienced family therapists from child psychiatry. Four were less experienced and came from the social welfare system. Two teams were formed with two experienced and two inexperienced therapists in each. The idea being that there should always be at least one experienced therapist behind the one-way-screen even when an experienced therapist worked with a family.

The aim was that the experienced should train the less experienced, that method and worldview would become anchored in drug treatment services and that we would do process and effect-research on the method.

We hoped that if the method proved to be successful there would be trained family therapists immediately available to start clinical work. In this way the program came to consist of four levels: treatment, training, anchoring and research.

As for the part of the program dealing with the effect, the 3-year follow-ups were terminated in the winter of 1993. A clinical report to the Swedish Board of Health was published in 1992.

A more detailed description of the heroin program can be find in a chapter in a coming anthology by Johan Sundelin and Kjell Hansson, ”Familjeterapi på svenska” (Family Therapy in Swedish”.

Psychotherapeutic theory as metaphors

Among other things psychotherapeutic theories are distinguished from each other by how they understand change and what produces it.

Psychodynamic theory views change as a result of insight. Structural family therapy views change as a result of a changed organization in the family. Strategic family therapy views change as the result of corrected dysfunctional hierarchies and perverse coalitions. The MRI-school views change as a result of people stopping the attempted solutions that have become a problem.

Different models explain each in its own way why people have problems. The above mentioned have in common that they see a problem as a symptom caused by some underlying disturbance. This underlying disturbance is the real problem that has to be changed, cured or corrected for the symptom to disappear.

To know what has to be done, we therapists explain to ourselves what we see happen, and at the same time, and within the same theoretical frame, we explain our own behavior in relation to it. ”I made an interpretation.” ”I did an enactment.” ”I did a lunch-session.” ”I made a phobia-training.”

Just like Cilla is making sense out of her reality with her story, we therapists create meaning in what we do by explaining it.

The frame and the metaphors we use will affect the behavior of our clients. You don’t have to go any further than to people in Freudian analysis that dream Freudian dreams, and compare with people in Jungian analysis dreaming Jungian dreams. What people talk about in the therapy room and how they talk about it has impact on what they do when they are at home.

Hence we create meaning in what we see, and we also create what we see through the meaning we give it.

Metaphors in structural/strategic family therapy

The basis for several theories about family therapy is the homeostatic model. The family is described as a self-regulating system where the symptom, for instance drug abuse, fills a function in the family. When someone improves – or changes his behavior in any other way – this will trigger feedback that will bring the family back to the same state as before the change.

Clinically this is apparent when the addict detoxifies; a crisis will arise somewhere else in the family, and this crisis is an implicit message to the addict to turn on again. The structure containing, or being the base of the dysfunctional interactions, must change

before the addict can be reliably abstinent. The families are stuck in their development and need help to liberate their resources in order to continue a healthy development, one that doesn't contain the addiction as an important part of the interaction. The organization and interaction in the families need to change.

The descriptive metaphors are (among others) dysfunctional interactions, over-involved parents, perverse triangles, pseudo-individuated teenagers, pathologic dependency and enmeshment.

> Edwin, 28, started experimenting with drugs in his teens and got quickly to heroin. He made one attempt at detoxifyng when he had a child with a woman he stayed with for almost two years. The detox went well, but as he says himself during the 'motivation-interview': "she couldn't accept a relapse and after that it was straight into it again."
>
> For the last six years Edwin has only been off drugs during a few short arrests and incarcerations.
>
> Although Edwin has an apartment of his own, he spends most of his time at his parents' home. He eats all his meals there and he often sleeps there too. Initially we are not allowed to contact his sister, but when this has been framed as his concern for her, and maybe also an expression of his mothers concern for her, he accepts that we invite her in.
>
> At the first family session two days after the motivation interview Edwin is high. The therapist asks someone to tell about the previous attempts to help him stop abusing drugs, and mother immediately starts speaking. When the therapist tries to short-circuit mother by asking Edwin, he gets confused and looks helplessly at mother who clearly affronted crosses her arms over her chest and looks to the floor.
>
> Father is markedly passive, but after a lot of supportive work and matching, he starts expressing displeasure with the behavior of his son at home. Edwin is careless, things are never in order, he does drugs and is negligent, and they argue all the time.
>
> While talking about this he now and then throws a worried look at mother who looks disdainful but doesn't comment.
>
> Father is asked to talk to his son about how he would like things to be at home, but mother now interrupts and says that if he (the father) weren't nagging so much there wouldn't be any fighting. When the therapist purposefully continues to support father, mother tries to get the sisters support. The sister desperately tries to stay neutral.
>
> The first session is terminated by the therapists telling the family that we think we can help them help their son in a different way from what they have been trying before, but we have to move carefully and not change to much to fast.
>
> We tell the family that we see a problem around father and son not being as close as they and the rest of the family would want them to be. We think that mother is the one who can help them get closer as she is close to both of them. We suggest that she sees to it that father and son spend a few hours together a couple of times a week until we meet next time.

This description was done after a session with a family in 1984. The metaphors deal with the imbalance between mother and father, the enmeshment between mother and son and the lack of closeness between father and son. The structure as highlighted in this session is the same as was saw in family after family during this period. Blurred boundaries between subsystems and inverted hierarchy. Similar structures were also highlighted in our work with families with anorectic members and many other problems.

The problem as defined in this session is possibly that father nags to much, or that mother is to kind or to mean, or that Edwin is not close enough to his father. No one knows how we will know when the problem is solved. The therapists though "know" that the problem is solved when the incongruent hierarchy is corrected and the parents can cooperate without the child coming between them. For the therapists the solution is

obvious. The coalition between mother and son must be broken to give the son a chance to mend for himself. This is not said, and can not be said to the family, at least in this session.

It is impossible to know what kind of information we would have gotten from this family had it been interviewed today. What we know for sure is that we would have met them very differently. We would have gotten a much clearer picture of what they did well, and not almost only a picture of their defaults and difficulties.

The clever shrudeness is a state of mind with the therapist that is built on the assumption that the family has to be tricked into health. Because of homeostatic mechanisms over which people have no power, or dysfunctional patterns of interaction, or unconscious object relations that all have in common that they are explanatory models or metaphors that therapists use to explain destructive behavior, family members must be lured or tricked into doing something different. The cleverness is to do it in the smoothest way possible.

Yesterday – today – tomorrow

A metaphor we use today is that the ”problem is the problem”. This means that we take what people say about their problem as a truth and we do not try to change their ideas around this. We have faith in that their truth is as useful as ours, and we no longer know best.

We saw people as basically resourceful, but we thought that they were stuck in structures and organizations that prevented them from using their resources constructively. Resources and hindrances were thus intimately connected to each other. Today we see people as resourceful and we see that they are already using their resources constructively (pre-session change and exceptions). Thus we don’t have to look for ”hidden” or ”stuck” resources. It is enough to listen respectfully, openly and actively to what people say.

In the same way we now see people functioning well together. We no longer see dysfunctional structures and perverse triangles, but we see people who interact without the problem being a part of their life. As we no longer see the problem as caused by some underlying reason, we can see the problem as an exception to what functions well. In this way we constantly discover more and more of good function and ”normal” behaviors, that is what the family thinks is good and normal and here variation is infinite. We almost always share the families’ view and we are almost never moralistic about it. Moreover as we hinted so many times in this book, the difference between the families world-view and ours is smaller than the similarities.

In this way the metaphors guide our work. The different metaphors today form the basis for an attitude that is different enough for us to think and feel it is different and it is this attitude that opens up for what we call constructive cooperation.

We hope that these metaphors in time will become different and form the basis for an even more respectful and efficient way to help people in difficulties.

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