HOT TIPS

by Insoo Kim Berg

The idea for this short column came from numerous questions I am often asked during the workshops and consultation sessions and represent typical struggles people have when they first encounter the Solution-Focused Brief Therapy (SFBT). The topics presented here will change from time to time and I hope this is informative and useful for you. Please let me know if you have questions or topics you want me to respond to.

How to Work a Client Who is not Motivated? By Insoo Kim Berg

This is a frequently asked question, particularly by those who work with "mandated" or "involuntary"clients. It is easy to see why clients who are "mandated" into treatment can be viewed as lacking proper motivation for change.

The best way to understand these "involuntary" clients is, to think of these cases as having multiple goals. That is, the clients might have very different desires and idea about what might be helpful to themselves than those who are mandating the treatment. It is very tempting for us to agree or disagree with the mandating person, such as, the judge, the social worker, schools principal, foreman on the job, and family members because we all want to see the client do what is good for themselves. The solutions the mandating person "impose" logically come from the way the mandating person has constructed the client's problem. After all, the mandating judge, teacher, doctor, or social service professionals all have the best interest of the client in mind. So do the clients. It seems so obvious that a father should stop drinking and stop verbally abusing his child who is not performing up to his ability. It seems so clear and simple to us, yet we also know that telling him what he is doing wrong is doomed to create "resistance." When asked in a proper manner, it is very likely that the father would say that he also wants what is best for his son. The only difference is that the father may not see the connection between his drinking and his son's difficulties in school.

Human motivation is much more complicated than what is the right or wrong thing to do. The problem is much more complex than a lack or an abundance of "motivation." The usual way of thinking assumes that the client's motivation is something that either the clients carry inside or do not. If they do not have a sufficient amount of "motivation," then it is commonly assumed that the clients have a problem. I frequently hear therapists use words like " she has an attitude that won't quit..... she blames everybody else," or "he minimizes his problem." This kind of causal thinking tends to make practitioners to blame the father for the child's misbehavior.

In addition, many of us who work with "mandated" clients ask ourselves, "How can I get this client to admit that she has a serious drinking problem?" When the therapist has this mind set, naturally the conversation with the client will flow from this thinking and clients will resist having somebody's idea imposed on them. It's not difficult to imagine what follows from this kind of thinking.

When I listen to case consultations or supervision, many practitioners talk about their cc mandated" clients as if they came with only two pounds of "motivation" when the client needs 50 pounds to accomplish the task at hand. And then of course, it is easy to attribute this limited amount of "motivation" to bad history, bad experience in his childhood, or that he has always been on a failure track, or that he has anti-social personality traits, or that he is "stubborn" and never admits his own mistakes. The problem lies in them or in their backgrounds. And of course the natural response to this kind of thinking is to either lower our expectations or to label them as this and that, and then point out where they have gone wrong. If the solution to this topic were that simple to fix, then

there would be no need for therapists!

What's an alternative way to think about this issue? I believe that clients' motivation is created together between clients and therapists through conversation. That is, it depends a great deal on what kind of conversation we choose to have. We can begin by asking the clients what their understanding of how they got to our office and what would be helpful to have happen, since they took the trouble to come to our office (or they allowed us to come into their house) and how that will make their life better, or how "being told what to do" is a problem for them. By insisting that they are the expert in their own situation, I am putting them in the role of explaining to me about how they got to "be told what to do."

The first working question I might ask is, "So, how is your drinking too much a problem for you?" This kind of question assumes that "drinking too much 'may or may not be their own definition of their situation and indicates to the client that we are interested in listening to their definition of the problem.

The implication of this kind of thinking is clear. We take a posture that clients know what is troublesome for them, what they wants to do about it, what have they been thinking about doing, and when was the last time when the drinking was less of a problem for them. When we take this posture and the conversations flow from these questions, you can easily imagine what position the clients will take. We are soliciting their ideas of what is problematic for them and what their solution to them is. Since these issues are generated from them, they are more likely to take ownership of the solutions than if they were forced on them. Therefore, the clients may arrive at the same conclusion about what to do that the mandating person wants them to do, but now it becomes their own idea. One can easily imagine the level of motivation to do what he wants to do will be much higher. Other good questions to ask are:

- Whose idea was it that you come to see me today?
- How did _ get the idea that you need to come here today'.?
- So what would your family (foreman, friend, PO) say how your drinking is a problem for you? Do you agree with their ideas?
- How she will know that the problem she thinks you have is solved?
- What will she be doing different then?
- What will be different between the two of you then?
- What else would be different in your life then?
- How would that be helpful?

The following posture that a therapist takes will enhance cooperative working relationship when working with "mandated" clients.

- Encourage the client to be the expert on her life.
- Pay attention to the client's language and use their words.
- Cooperation is constructed between clients and practitioners.
- Set aside any information you might have about the client and be willing to listen to her own view of the situation.
- Help clients define what the problem is and what steps they may need to take to find solutions.
- Negotiate solutions that clients can carry out realistically (has done it before, etc).

When do you ask the Miracle Question? Does timing make a difference in the client's ability

to describe their miracle pictures in useful details? By Insoo Kim Berg

Of course. Timing is everything in such complex activities as carrying on therapeutic conversations when the client is so overwhelmed by very serious and complicated problems. Most beginning therapists have had experience of asking this wonderful and useful questions, only to be disappointed by the response, such as completely ignoring the question, or "I don't believe in such stuff," or "It's such a silly game," or "I really have a serious problem" and so on. The question of "timing" is one of those things that are very difficult to teach and describe but can be done. The best way to describe when to ask the miracle question is not measured by how many minutes after the beginning of the session you ask the miracle question (as someone actually asked this question once). There are rare instances when the client blurts out as soon as she sits down, such as asking for a "magic bullet magic pill," or "secret to life's problems, etc. Of course when they introduces this opening, I want to capitalize on this by saying something like, "since you mention a magic pill (secrets of life, silver bullet), I have a strange question to ask you. Well, not exactly a magic pill but I suppose you could call it a "magic question." Then the client and I are off and running with rich details of the solution picture. Most of the time, however, it is not that simple or easy. Therefore, it takes some work on both sides. My guideline for when to ask this question is when both the client and I have general idea about what the client is looking for, for example, "We want to stay together I need to get my life on track I need to figure out how I can stop feeling so bad all the time," "I am not doing what I am capable of doing," and so on. Once I turn these "negative" goals into a "positive indication or presence of some positive indication that her "life is on track," so that we have an agreement on what the solution would be like, and how others will recognize that she is doing what she is capable of doing, etc. I want to make sure these general directions of solutions the client is seeking is socially anchored so that perhaps her children will know that she is getting up on time to get to work, etc. When we have agreed on a broad view of the client's goal, asking miracle question will provide details of the solution picture. Of course, the more detailed, the better, since these richly described pictures will not only individualize the solutions but also the client will generate more ideas even after the session. Again, it is important to situate the miracle into client's social context so that it becomes not only realistic but also how others in her environment will respond to her in such a way that other's response to her becomes a reinforcement of her new behavior, which in turn encourages the others to respond to her in a positive manner.

Does SFBT work with "severe" problems like PTSD or personality disorders?

The "problem solving" paradigm sees the professional's "expertise" as his/her ability to accurately diagnose psychiatric problems such as PTSD and other disorders and then find matching solutions that will "dissolve" the problems, much as the medical model treats the human body.

Coming from the social constructivistic approach, SFBT believes that problems and solutions are socially created, using language as the primary tool. In addition, SFBT works with the person's personal meaning one has about his/her experience, rather than the event itself Thus, finding out what meaning the trauma of being assaulted has for the person is more important than the fact that she was raped. Of course the common reaction to an assault can be generalized but perhaps this person has experienced assault before or has witnessed her mother being stabbed when she was a child. SFBT considers what this means to this person and then construct what might be the first small step toward her feeling a little bit better, such as being able to sleep at night without flashbacks, etc. if that is what she wants.

In addition, SFBT believes that terms like "personality disorder" are not a helpful or useful ways to create solutions because the word have many connotations attached to them, along with all the implications of what it means both for the client and the therapist to have this "disorder "

SFBT generally tries to avoid labeling or describing a person by psychiatric terms because the label itself tends to stand out, as if that's all there is about this person. A woman with a "borderline disorder" is also a loving mother, a competent accountant, a good friend, etc. and these other, functioning aspects of her disappear from our discussion of "borderline" and only her pathology stands out.

Again, not everyone who were sexually abused or have substance problems attach the same meaning to this experience. And individualizing treatment means staying close to what the client wants and then generating solutions that will make sense to her, and then finding out from her what she found helpful to her so far and then getting her to "do more" of what has been helpful, until she is satisfied with how her life is going. Because all such discussions take place through the language, we pay close attention to how the client changes her language and her behavior.

References:

Steve de Shazer. (I 994) Words were Originally Magic. W. W. Norton: New York.

How do you Keep SFBT from being Mechanical?

There is a great deal of misperception that SFBT is "mechanical" or that it is not sensitive to client's pains. Nothing can be further from truth. I can't tell you how many times people from the workshop audience come up to me during the break and says how sensitive and in tune with the client's feelings I am when they see my work on videotapes.

Perhaps one possible explanation: many in the audience come up to me and point out that they have all read the books that Steve de Shazer and I have written on SFBT but that there is no mention of how to deal with clients' pain. They are right about this. We do not generally devote a great deal of time to client's suffering and pain or their dysfunctional symptoms either in books or in sessions.

The reason clients come to us and seek our help is because they are hurting and they are unhappy with how their life is going and want to change to something, making life more satisfactory and satisfying. Since we do not place emphasis on the detailed history of client's problems, we also do not emphasize the pain and suffering the client is enduring. We think it is more useful and helpful to focus on how they are managing to get by under such difficult circumstances rather than focusing on how much they suffer. Linguistically, the more one emphasizes any topic, the bigger the topic of conversation becomes.

In addition, writing, like speaking, is such that in order to be succinct and focused, one can only write or talk about one thing at a time. This leads the reader to believe that the author is only talking about one thing and not others. Therefore, many in the field report to me that they are very surprised to see from videotapes that I am doing lots of things that are not described in the books. Of course. The therapeutic process is a very complex, multi-faceted activity and it is impossible to describe everything that occurs in a single session. One has to experience it. As Wittgenstein put it: "What can be shown, cannot be said."

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