Introduction to
Solution Focused Brief Therapy

for

SCHOOL PSYCHOLOGISTS
Ministry of Education WA

by

Andrew Turnell and Steve Edward
Centrecare Brief Therapy Service

- May 20th - 21st -

Copyright © 1993 Centrecare Brief Therapy Service and
Michelle Wilson and Andrew Turnell
Permission must be obtained to reproduce or copy material herein.
## CONTENTS

1. Solution Focused History 2
2. Solution Focused Central Philosophy 3
3. Assumptions of Solution Focused Therapy 4
4. First Session Summary 5
5. Of Miracles and Goals 6
6. Of Exceptions, Past Successes, Pre-session Change and Parts of Miracles 8
7. Scaling Questions 10
8. Co-operative Client-Therapist Relationships 13
9. Message 17
10. Tasks in Solution Focused Brief Therapy 19
11. Second & Subsequent Sessions Map 21
12. Second & Subsequent Sessions 22
13. How Do We Know When to Stop Meeting Like this? 26
14. Maps Out Of The Mire 28
15. Coping Questions 31
16. First Session Worksheet 33
17. Second & Subsequent Sessions Worksheet 35
18. Selected Bibliography 37
SOLUTION FOCUSED CENTRAL PHILOSOPHY

RULE ONE >>>> IF IT AIN'T BROKE >>>> DON'T FIX IT

RULE TWO >>>> ONCE YOU KNOW WHAT WORKS >>>> DO MORE OF IT

RULE THREE >>>> IF IT DOESN'T WORK >>>> DO SOMETHING
DON'T DO IT AGAIN DIFFERENT
ASSUMPTIONS OF SOLUTION FOCUSED APPROACH

1. **Clients have resources and strengths to resolve complaints.**
   The task of the therapist is to access these abilities and put them to use as the client frequently loses sight of their problem solving strengths.

2. **Change is constant.**
   If you assume that change is constant you'll behave as if change were inevitable and give the client the impression that it's surprising if the complaint persists.

3. **The therapist’s job is to identify and amplify change.**
   We create a particular reality by the topics we choose to focus on as well as what we ignore during a clinical session. We think it important to focus on what seems to be working, however small, label it as worthwhile and enlarge upon it.

4. **It’s unnecessary to know a great deal about the complaint to resolve it.**
   Typically, solution oriented therapists do not find it useful to gather extensive historical information; often only the bare minimum is necessary to begin resolving the complaint. What is significant is what the clients are already doing that's working.

5. **A small change is all that is necessary.**
   A change in one part of the system can effect change in another part of, and/or the entire system. Erickson used the metaphor of a snowball rolling down a mountain to describe the importance of small changes. Once the ball gets rolling, the therapist merely needs to stay out of the way.

6. **Clients define the goal.**
   Solution oriented therapists don't believe that there is any single 'correct' or 'valid' way to live one's life. What is unacceptable behaviour in one family, or for one person, is desirable behaviour in another. Therefore clients, not the therapists, identify the goals to be accomplished in treatment.

7. **Rapid change or resolution of problems is possible.**

8. **Focus on what is possible and changeable, rather than what is impossible and intractable.**
   For change oriented therapists, the focus of a clinical session is on the changing and changeable aspects of the client's life, not on aspects of the client's situation that are not amenable to change.

FIRST SESSION SUMMARY

1 Social Stage

2 Problem Description
   - Allow family to exhaust problem description, but no tracking or deepening of the descriptions.
   - Note down any things you think might be pre-session change or exceptions, but don’t elicit or make more notable at this stage.

3 Miracle Question Process
   - Warm-up to MQ: This question may be a little strange . . .
     This question may take some imagination . . .
     Can I change tack?

   - The Miracle Question
     Deliver it slowly, give it space; allow it to take on its own life.

4 Part of Miracle/Exceptions
   - Are there times when part of this miracle is happening?
     (Pre-session change and exceptions are now seen as part of miracle rather than non-problem at Milwaukee)

5 Scales
   - Situation Now
     Then what would be a sign of first step taken?
   - Confidence of Change
   - Willingness to do something

6 Anything Else
   - Is there anything else you feel I need to know before I take a break?

7 Break

Message:
Deliver slowly, look for nods and build ‘yes set’ if clients not with you, change tack.

- Compliments: General compliments possibly including: ‘your situation is very difficult’. Compliments are given in relation to client’s goals.
- Bridge: Explanation of the task possibly including: “your situation will take a lot of hard work to solve”
- Task: Remember Visitor/Complainant/Customer issue
Warm-up to the Miracle Question:

- Can I change tack?
- This question may be a little strange . . .
- This question may take some imagination . . .

The Miracle Question

- "Suppose a miracle happened while you are sleeping tonight and the problem(s) that bought you here are solved. Since the miracle happened while you were asleep, you don't know your problems are solved, so how would you know this miracle had happened, what would be different (tomorrow morning)?"

- Deliver it slowly, give it space; allow it to take on its own life. Let the client list off as many things as they can, unaided, while you make note of them. Later you can return and deepen each item.

Follow-up questions to deepen the miracle:

- "What else?, and what else?, and what else?, and what else?"

- In client:
  
  "What will be different about you after (when) this miracle has happened?" What else? and what else?

- In others:

  "What will be different about others (father, mother, partner, sister, brother, employer, teacher, friend etc) after (when) this miracle has happened? What else? and what else?"

- Relational:

  "What will the other person notice differently about you after (or when) this miracle has happened? What else? and what else?"

- Relational questions, the next step: Change creating change.

  "When they notice that difference about you, how do you think they'll respond? or when they notice that difference about you how will that change things for you?"

- When the client returns to the problem:
“So how would that (the problem) be different after this miracle?”

Some people really go for the Miracle Question straight off; for some it comes more slowly. Don’t give up, it often takes effort on your part to create space for the miracle . . . you are creating solution space.

**Remember:** The solution does not have to equate to the problem.

**Goals**

What you are looking for in the miracle question process and all Solution Focused Therapy are goals, goals, goals and more goals: The client’s goals!

The characteristics of useful goals:

- They are multiple and various.
- They describe presence (someone doing something) rather than absence (someone not doing something).
- They are small and concrete.
- They are interactional and observable.
- They are realistic and achievable.
- They require thought and effort, in other words they require hard work.
Part of the Miracle

All of the above are part of an exception focused model of Solution Focused Brief Therapy (SFBT). The model has evolved such that, instead of looking for pre-session change/exceptions early in a session, the Milwaukee style is now to look for exceptions after the miracle question, and phrase the exceptions questions in terms of part of the miracle.

Exception search is now undertaken in this way:

"Are there times when a part (even a small part) of this miracle is happening?"
Check with everyone in the session. Track: who, where, what, when and how.

"How is that different?" "Who else noticed?" "If this was to happen more often, how would that change things?"

Check with any exceptions; are these things replicable? Exceptions viewed as accidental aren't usually replicable and therefore are usually not very useful. So:

"What would need to happen for you to do this again?" or "What would need to happen for this to happen again?"

Pre-session change

Weiner-Davis, De Shazer and Gingerich (Using pre-treatment change to construct a therapeutic solution: A clinical note. Journal of Marital and Family Therapy, 13(4). pp359-363.) show that between the time of making the appointment and actually commencing therapy, two thirds of all clients report improvement in their situation. Pre-session change questions track this with questions like:

"I'm wondering if between when you originally phoned to make the appointment and now that you've come in, you have noticed any improvements in your situation?"

If yes, track in detail: who, where, how, when, who else noticed and what difference did that make.

Past Successes

When a person is facing a problem, chances are that they have faced this or similar problems previously. Questions to ask are:
"Have you faced this sort of problem before?" If yes: "How did you deal with it then?" Was that a useful thing(s) to do? If yes: What would need to happen for you to do that again? If no: What did you learn from that experience?" and/or "What will you do differently now, given that experience?".

Exceptions

Exceptions are times when the problem is not happening or, better still, times when the problem might have happened but didn't. For example a boy being asked to truant by his friend and him turning his friend's request/suggestion down, is a clear exception.

Essentially, once the therapist/case worker has discovered any small exception, he or she then constructs a sequence with the clients in which the exception is further illuminated from as many perspectives as possible.

Always check: "Was/is that different?" You may see it as an exception but the most important thing is that the clients themselves can see it as an exception.

Exception questions and tracking of them can include: "Are there times when you would expect the problem to happen and it doesn't? How did you get that to happen?" (positive blame).

"Was there a time recently when this problem could have got on top of you but you did something to fight it off? What did you do?" (This question is particularly good for depression/phobias/dealing with effects of abuse).

Exceptions cont.

If some time has elapsed since the problem last occurred: "I'm curious (always be curious!) as to how you have stopped the problem from happening in the interim? How did others help?"

"In the past week, were there times when things have been even a little better? Tell me about those times" Track: who, what, when, where, how and what difference did that make.

"Are you surprised by these (exception) times?" "What does that tell you?" (for example address this to the mother of the boy who's son rejected the idea of truanting).

See Lipchik article "Interviewing with a Constructive Ear" for more examples.

"
Scaling questions are used to get the client to place problems, priorities, successes, emotional investments in relationships and self-esteem levels on a numerical scale.

Scaling questions are very powerful and have many uses. These include:

- Firstly, built into a scale is the assumption of change.
- Scales also often use a description of the client's desired solution at one end of the scale so the client has a sense of goal direction.
- Thirdly, it implies a degree of control on the part of the client for navigating the direction e.g. "What could you imagine yourself doing to bring the situation from 7 to an 8?"
- The goal of the client is made objectifiable and quantifiable with scaling questions and this allows identification of small, meaningful steps that can be evaluated.
- Scales also provide a distinction between the problem state and progress toward the solution.

Use of Scaling Questions, Session One:

Situation now

"If 1 is the worst this problem has ever been and 10 is that the problem is solved (or the miracle has happened), where would you put yourself now?"

If the client responds with a high score, you can be curious as to what makes the score so high. This can achieve a list of what's happening now that's already working:

"What have you done that's helped you get to a 7?"
"How did you manage to get to a 7?"

First step/next step

Wherever the score is, the next step is to use the scaling questions to ask about the first sign of change.

"What will a 4 look like?"
"What will be happening at a 2 that's different than now?"
"If things were just a little bit better, say a 1, what would be different?"

**Willingness Scaling Questions:**

The willingness scale can be used to give an indication of the type of task that can be given to the client and is generally used at the end of the first session:

"If 1 is 'I'm not really willing to do anything to change this situation' and 10 is 'I'm willing to do anything to resolve this', where are you now?"

**Confidence Scales:**

'Confidence' scales are used to assess the client's confidence in their ability to control actions and create change in their life.

"On a scale of 1-10 where 1 is you have absolutely no confidence that this problem can be resolved and 10 is that you are completely confident that this problem can be resolved, where are you now?"

"On a scale of 1-10, 1 is 'I have absolutely no confidence that we can continue to sustain and improve this situation' and 10 is 'I'm confident we can continue and sustain the changes you've begun', where are you now?"

If the response of the client is high, a follow up question will be:
"What makes your confidence so high?" This results in a list of things already working in the client's life.

If the response is low, a follow up may be:
"What would be the first sign that would move you one notch up the scale and give you a little more confidence?"

**Use of Scaling Questions, Second and Subsequent Sessions:**

Scaling questions are used in almost every session of solution focused therapy. They are invaluable in tracking the client's goals and the client's sense of progress. As such, the 'situation now' scale is used in almost every session as a quick and clear way of keeping track of progress. This leads naturally into questions such as:

"What is happening now that causes you to say things have increased by two points since I saw you last?"
"What have you done to move up the scale like this?"
"What has (husband/wife/child) done?" (See Second Session discussion for questions and ideas and also what to do if the client has moved backward or remained the same on the scale.)
'Next step' scaling questions are likely to be used after the 'situation now' scale and follow up. 'Confidence' scales are invaluable to keep using as a guide to what the client is willing and able to tackle.

The 'situation now' scale is also the perfect guide for when to conclude therapy, particularly when asked in tandem with a question like: "Where would you need to be on the scale so that you would feel you have achieved what you wanted from coming to see me?"

**Relationships and Scaling Questions:**

'Relationship' scaling questions can be used to access the client's perception of change, confidence and willingness in their spouse, child, parent or significant other.

"On a scale of 1-10, where 10 is your problems with your child are solved and 1 is they are the worst they've ever been, where would you say your child is today?"

"If I were to ask your child how well s/he thinks s/he is doing on the same scale, what would s/he say?"

"If I were to ask him/her where you would put him/her on that scale, what would s/he say?"

"When you have moved from 7 to 8, what will . . . . . notice about you?"

"When you achieve your goal, what will be different between you and . . . . . ?"

"What would . . . . . say will be different for him/her?"

"On the same scale, how much do you think your husband/wife is willing to work to solve his/her drinking problem?"

When someone other than the client needs to be convinced:

"What would your husband/wife need to see you do so that s/he would be more willing to work on your marriage?"

The actual number given is not as important as the scale's usefulness in inducing change.

**Psychodiagnosics: Solution Focused Style**

Ron Kral in the "The Q.I.K. (Quick Interview for Kids): Psychodiagnosics for teens and children - Brief therapy style" (Family Therapy Case Studies 1989, 4(2), pp61-65) uses a series of scaling questions to develop a Solution Focused assessment process. It is a particularly invaluable resource for those times when the professional has to interview a child or teenager and has little idea what to discuss with the young person.
Studies (Hester & Miller 1989*) demonstrate that compliance with treatment increases dramatically when therapists co-operate with the client by allowing them to set and work toward their own treatment goals. In particular, cooperation can be facilitated by the ways that treatment becomes individualized. Individualization begins with the identification of the type of relationship that exists between the client and the therapist.

Identification of the type of relationship between the client and the therapist often helps to determine the type of therapeutic intervention most likely to increase client cooperation and participation in the therapeutic process. The Solution Focused treatment model distinguishes among three types of client-therapist relationships:

1. Customer type relationship
2. Complainant type relationship
3. Visitor type relationship

It is easy to mistakenly conclude that these refer only to the client, however these descriptions describe the type of relationship between the client and the therapist not individual characteristics, attributes or traits of the client.

This concept also encompasses the idea that the process and outcome of therapy is dependent on the interaction between the client and therapist and not based on some individual trait in the client themselves.

When looking at the therapeutic relationship it's important to remember that it is dynamic, fluid and in a state of constant change throughout the therapy.

* Hester & Miller 1989 Handbook of Alcoholism Treatment Approaches, Pergamon Press

**Customer Type Relationship**

The customer type of relationship occurs when, during or at the end of a session, a goal for treatment has been jointly identified by the client and therapist. In addition, the client sees him/herself as part of the solution and expresses a willingness to do something to find solutions to the problems, either verbally or non-verbally.

The desire to have a customer type relationship often is so strong in the therapist that s/he may act as if the client is a customer and then become irritated when the client is not receptive. With clients where there is a customer type
relationship, the intervention message given should provide lots of positive feedback about what the client is doing right. Agree that the client is right about needing to do something to find solutions to this problem and, since the client is willing to take steps, the therapist can give behavioural tasks in combination with an observational task. The therapist can ask the client to notice changes that occur when the client starts to do something different. For example the therapist could say: "There are a number of things that really impress us. In fact with all of these things that we have been talking about and that you have been doing, it's kind of hard to know where to start. One thing we really appreciate is your honesty and that you came in here and decided to be honest and straight about what has been going on. Also, it is impressive that you have a clear sense about what is important to you. For example, you have been staying away from alcohol and being the kind of person you want to be. We are amazed at the many choices you have made for the better and this means you really know exactly what you need to do in order to continue the changes you have started in your life. The suggestion we have for you is that you continue to do what you are doing that helps you have days like these and pay attention to the additional things you can do to stay on track the way you have been."

**Complainant Type Relationship**

A complainant type of relationship exists when, over the course of the session, the therapist and the client jointly identify a goal or complaint for treatment but have not been able to identify concrete steps the client needs to take to bring about the solution. Usually these clients can describe the complaint or goal in great detail. Often, however, they may not readily see themselves as a part of the solution and may, in fact, believe that someone else must act to create change.

These clients are usually very good at describing patterns and sequences to the problem and often see themselves as a victim. Usually they're either not committed to take steps to solve the problem or not clear that they must take steps.

In this situation the client is complimented on all the useful information they've provided, (as they've usually given clear detailed observations) and on the things they're doing that are good for them. These clients do not see themselves as an active part of the solution but are good at "thinking about" and observing. Due to this, the intervention will usually ask the client to think about/observe something positive. In this the therapist matches and utilizes the interactional style of the client.

For example the therapist could say: "Certainly, Tom, you have given a lot of thought to this problem. You even have some ideas about what you can do. For example, you said "...". This has been a serious problem, and, like you have told us, you don't want to do this again. So, between now and the next time we meet, we would like you to think about all the things you are doing that help you from having to do this again, and anything else you need to do, so this doesn't happen again."
Visitor Type Relationship

This type of relationship exists when at the end of the session the client and the therapist have not jointly identified a complaint or goal on which to work. Additionally, the client may indicate either that there is no problem requiring treatment or that the problem belongs to someone else. This relationship is one of a visitor. The client may have "gripes" but may see no reason to change themselves. Often these clients are referred by someone else and the problem may only be to get the referring agent "off their back". The therapist agrees that there may not be a problem that requires therapy but remains willing to help the client determine if there is something else on which they'd like to work.

The message in this relationship type includes lots of positive feedback on what the client is doing right and what they're doing that's good for them. Let the client know the therapist appreciates how difficult his/her life is and that s/he's having a tough time. The team (or one part of the therapist) can be worried about the future and consequences of not solving the problems.

Allow time for another appointment. Compliments are utilized because they promote the return of the client and facilitate increased co-operation and participation of the client in subsequent sessions and the treatment process in general.

The therapist may feel frustrated that they have not done enough and want to confront the client aggressively. Research, however, demonstrates that aggressive strategies have high casualty rates. (* Miller 1985)

The therapist may say: "The team and I want to thank you for coming in under the less than ideal circumstances that you have described. We are very impressed that you were willing to assume responsibility, to take the 'bull by the horns' so to speak. It is clear to us that you not only want to comply with your captain's wishes but want to do what is best for you, your family, and your career."


Difficult, Resistant and "In Denial" Clients

These clients most often result when the treatment professional misclassifies the type of client-therapist relationship. Often the therapist has tried numerous interventions to which the client has neither complied nor responded and the therapist may work harder at "helping" the client with complicated, creative or aggressive confrontational intervention tactics. In general we suggest that the therapist reconsiders the type of relationship and treat the client accordingly.
Alternative Strategies

The Hidden Customer: The client may not be a customer for dealing with the referred problem but they may be a customer for dealing with something else. The rationale behind this is that co-operation with the client's view of the problem and/or what s/he wants to achieve in therapy promotes co-operation in the client - therapist relationship and thereby facilitates progress toward treatment goals.

The Other Customer: Often clients are referred, or forced into therapy by their spouse, employer, the judicial system, and may feel that they don't need or want counselling. In this situation, the therapist can focus on what needs to happen for the referral person to be confident that the client can stop attending counselling and ask: "What needs to happen for the courts to be convinced that you don't need to come here anymore?" In such cases it may be useful to contact the referral source to find out what they would like to see happen as a result of treatment.
Toward the end of the session a brief period of time is scheduled for a "consultation break". During this time the therapist leaves the room for 5-10 minutes to review the client's goals, the type of client-therapist relationship and develop compliments. This short thinking break allows the therapist to process the session free from the immediate task of attending to the client's needs and the influence of the immediate interaction with the client. The short pause also heightens the client's anticipation of what the therapist will say upon his/her return. Lipchik calls this the 'Yes Set'.

The message is constructed of three parts:

1. Compliments
2. Bridging Statement
3. Task

**Compliments**

The first part of the intervention or message is the compliments. Compliments are a powerful intervention used with all cases regardless of the type of client-therapist relationship. Compliments are used throughout the treatment process. Compliments enhance co-operation with the client even when the relationship is already positive. They also reinforce the client's feeling of competency, self-esteem and give credence to their view of the world.

Compliments can be given on anything that will enhance the client's self-esteem and competency, but the compliments the therapist makes must be genuine, sincere and honest in order to engender client confidence in the therapist. The therapist should point out any positive, successful or useful efforts the client has made in his/her desire to move toward his/her goal and, whenever possible, use the client's words to enhance co-operation. Use of the client's idiosyncratic words engenders in the client a feeling of being understood and reassured by the therapist, thereby reducing the client's need to defend her/his position.

The compliment part of the message often begins with an indirect compliment. This is generally a statement acknowledging that what the client/family has been experiencing has been difficult (sometimes extremely difficult).

An example of compliments in a visitor type relationship:

"John, it's obvious that you've been through a lot in the past 12 months and we are very impressed that you are here today even though this is not your idea. You certainly had the option of taking the easy way out by not coming. Your willingness to put up with many demands that seem unreasonable, including
being here today, shows that you are the kind of person who wants to do the right thing. It has not been easy for you to be here today; having to give up your personal time, talking about things you don't really want to talk about, having to take a bus and so on. But we are impressed with your willingness to co-operate with us today . . . . "

Except on rare occasions when the client is squeamish about receiving compliments, and in extremely rare situations where the therapist is unable to find anything positive at all, we find that using compliments enhances co-operation with the client.

**Bridging Statement**

It's important to always give a rationale or explanation for suggesting a task. Even if the only goal that emerges at the end of the session is to have the client return for a second session. A simple statement such as:

"Since there is a serious disagreement between you and your probation officer about what kind of treatment you need, I'd like you to return next week so we can get a better idea of how to accomplish both."

The rationale must make sense from the client's perspective and thus must fit with their view as being reasonable and worthy of doing.

A helpful bridging statement may begin with repeating what the client stated during the session:

"Because many things you have tried did not work. . . . . . . . . ."

"Since your boss misunderstood your drinking problem . . . . . . . . ."

"Because your son needs to take more responsibility for himself . . . . . . . . ."
In suggesting tasks, always remember whether you have a visitor, complainant or customer relationship with your client.

**Visitor relationship:** only give compliments.

**Complainant relationship:** give compliments and observe only tasks.

**Customer relationship:** give compliments and observe or 'do' tasks.
(Only give 'do' tasks to customers.)

**Observe tasks:**

- **Formula First Session Task:** "Between now and next time we meet, we would like you to observe, so you can describe it to us next time, what happens in your life that you want to continue to have happen".

- **Specific observation:** "Keep track of what you are doing this week that makes you feel (even a little bit) more whole". "Observe the times between now and next time when you could have fought with Mary and didn't. Notice how you (and/or others) made that happen". A specific observation task is generally linked to an exception/part of miracle scenario.

- **Spanish Task: Milwaukee variation** "In the next week, I (or we, the team) are sure that both of you will do some things to improve the situation. We are willing to bet though that each of you won't notice what the other person does". Particularly good for feuding couples in competition with each other. You’re setting them up to outdo each other in something positive.

- **Spanish Task, Perth variation:** "Clearly you're both doing things to make things better but when things are so bad it's hard to notice what the other is doing (this is an example of a bridge). So, between now and next time, we want you to notice the things the other person does to improve the situation (or, it can be made specific; to deal with the wet beds, the depression etc). We want you to observe the other person but the first person you talk to about this is us, in other words don't talk about this with each other".
This is particularly useful for parents/children who are feeling unacknowledged by the other.
Other tasks for the Complainant:

- For a person who is procrastinating about a specific action (leaving a marriage, confronting a child etc), which they keep talking about: "Between now and next time we meet, we would like you to think about, so you can tell us, what would need to happen so that you could leave your husband (or confront your son etc)."

- Prediction task: "Over the next week, we want you to observe your son closely and, each night before going to bed, we want you to predict whether tomorrow you think he’ll go to school or not". Prediction tasks can be for anything and are particularly useful where someone feels they have little or nothing to do with the problem.

'Do' tasks

Remember: Only give 'do' tasks to customers.

- Pretend miracle: "Between now and next time we see you, we want each of you to pick one day and for that day act as if the miracle has happened. Don’t talk about this with each other because when you come back we want you to tell us which day you think the other person chose for their miracle day". This should be used when you have a well described and detailed miracle scenario and each participant is motivated (scale the motivation) to do something.

- Do more of existing solution: "Between now and next time we see you we want each of you to do . . ." (whatever the client has identified as an exception or part of miracle).

- Generic task or do something general: "Between now and next time we see you, we want each of you to do everything you need to do to be most relaxed (more whole, happier etc)". Use this where the client’s goal is vague but they do want to do something.

- Randomizer plus action: "For the next week, we want you to toss a coin each evening before you go to bed and if it comes down heads we want you to act all day as if you’ve decided to (leave your wife, change jobs, confront the perpetrator etc). On the other hand, if it comes down tails we want you to act all day as if you’ve definitely decided you won’t do that. Notice what difference this makes on each day so you can tell us about it next time." This is most useful for a customer who is vacillating between two different actions.

There are other tasks in the Solution Focused literature, but those described above give a good feel for the style.
Second and Subsequent Sessions

- Are changes related to goal?
  - Yes: Are there changes?
    - Yes: Better?
      - Yes: Do Something Different
      - No: What else needs to happen?
    - No: Is it enough?
      - Yes: Terminate
      - No: What else needs to happen?
  - No: Better?
    - Yes: Are there changes?
      - Yes: Do Something Different
      - No: What else needs to happen?
SECOND & SUBSEQUENT SESSIONS

In second and subsequent sessions the therapist aims to maintain and enhance the progress of the clients toward their goal. The session involves eliciting, amplifying and reinforcing progress the client has already achieved, then clarifying what else needs to happen for the client to continue to move toward solutions.

This occurs through Solution Focused amplification dialogue around even small successes, progress scales to assess where the client feels they are now, presence of the next step and the message.

1. Amplification Dialogue

Elicit

The therapists choice of what to pay attention to, as well as what to ignore plays a significant role in deciding the focus of the session and it's outcome. Eliciting successes during the beginning of the session increases the sessions solution focus and facilitates following discussions of more serious problems to be less overwhelming.

Orienting the client toward discussing successful activities means eliciting successes to the goals the therapist and client developed during the first session. Clients may be momentarily disoriented because they still expect the therapist to focus on problems.

To elicit successes the family/individual has achieved over the past week, a Solution Focused therapist will often start the second session with one of the following questions:

"What's been better since I saw you last?"

"What's been going well since I last saw you?"

"What would your (son, teacher, wife) say is better?"

"What else?"

Amplify

Amplifying the small but significant changes the client has made can be achieved by asking detailed questions regarding events the client describes.

When: "When did this happen?" Ask about sequences - "then what happened? then what..."
Who: "Who else noticed? How did they respond? What tells you they noticed?"

Where: "What was going on at (a place) that helped?"

How: "How did you do that? How did you know that was the right thing to do? How do you think (your son, the judge) decided to do that? How did (this change) help?"

Reinforce

Client's successes should be reinforced or "cheerleadered" by the therapist who admires the client's resourcefulness, wisdom and commonsense in making small but significant progress toward his/her goal.

Non-verbals: Lean forward; raise eyebrows; pick up your pen; and take notes; wake up.

Non-specific: Interrupt, asking "say that again" or "what did you say?"

Compliments: ..........................

The amplification dialogue may be, but is not necessarily, a linear process. This depends on the therapist. With a family for example the therapist may find it more useful to elicit all "What's betters?" from first the mother, then father, then children, before moving into amplifying. Hearing what's better from all family members first enables the therapist to selectively amplify those issues that are commonalities to all members and those issues that will facilitate the family's movement toward their solution.

2. Scaling

Progress

After the amplification dialogue the therapist will normally ask the progress scaling question to assess where the client is now.

"On a scale of 1 - 10, 1 being the worst it's been for you and 10 being the way you want it to be, where are you now?"

Next Step

The next step is used by the therapist to identify what continued progress would look like for the client. For example, if the client is currently at 4 on the progress scale.

"What will be happening at a 5 that's different from now?"
What's been better?

How's that been going?
How's that helping?
What else?

What do you think he'll say?

When your husband notices, how will
that change things?
What else has been different?

What changes has your daughter noted
about you?
What else?

Who else would know you're making changes?
"What will 5 look like?"

"If things were to improve just a little more, say to 5, what will be different?"

**Presence of Step**

The presence of step questions aim to find out if part of the goal is already happening now.

"Are there any times now when this is happening even a little?"

"Have there been any times in the recent past when you have been/ your son has been more .........................?"

**Confidence**

The confidence scaling question is used to assess the clients confidence in their ability to continue to move toward their solution.

"On a scale from 1 - 10 where 1 is I have _no confidence_ I/we can continue making progress toward our goals and 10 being I'm _pretty confident_ we can keep this progress going, where would you be now?"

**Next Step**

The next step in confidence can be asked in the following way.

"When your confidence has increased even a little what will be happening different from now?"

"What would have to happen for your confidence to increase even a little?"

**Presence of Step**

"Have there been any times in recent past when you have been even a little more confident?"

"Are there any times when your(son, husband, mother) has been ......................... even a little?"

3. *Anything Else*

4. *Break*

5. *Message*
IF IT'S NOT BETTER

When the client reports that the situation is "not better", it usually means that the changes are not dramatic and fast enough to meet the client's expectations, that they are looking for big changes, or the changes are not directly acknowledged as related to the client's goal.

Such feelings of frustration must be acknowledged while at the same time the client's attention can be drawn to "small changes" that can be highlighted and made significant.

Remember that if the client has had an upsetting day just prior to the session, this may colour his/her perception of the whole week. So, accept the client's perception as valid and then review the week in detail. In this process you can usually find some instances, although small, where they behaved differently creating some change related to their goal.

UTILIZING SETBACKS

When a client faces a setback from their goal maintenance, often they immediately lose perspective and become overwhelmed with various feelings. The therapist's role is crucial at this point in helping the client to see the successes s/he has had prior to the setback and in pointing out that the important task is to return to the original goal as soon as possible.

"How is this setback different from the last one?"

"What did you do differently this time?"

"How did you figure out to do that?"

"Who did what and when to make this different than last time?"

"What would . . . . . . . . say was different about this time?"

"What have you learned about yourself from this experience?"

"What will you do differently as a result of this?"

"What do you need to do more of?"

"How will you make sure you do that?"

"How will that affect your life?"
HOW DO WE KNOW WHEN TO STOP MEETING LIKE THIS?

The object (of therapy) is to get the client out of therapy and actively and productively involved in living his or her life.

Dolan 1985 p29*

Goal Achievement as Criteria

In Solution Focused therapy or solution determined conversations, the client's goal achievement signals to client and therapist alike that a solution is developing or has developed. This generally means the end of therapy.

It is the client's responsibility to tell us about the changes they wish to occur, we (therapists) take a very active role to assure that the goals are attainable and concrete enough so that we will know when we get there. Goal setting is a cooperative negotiation process. "The goal (in Solution Focused Brief Therapy) is best thought of as a member of the class of ways that the therapist and client will know that the problem is solved." (de Shazer 1988 p93*)

Revising Goals and Assessing Readiness for Termination

Termination of a case starts at the beginning of a case and ends when the case ends. Between these two points there is continuous and ongoing evaluation as to how close you are to achieving the goals. As time goes on, you need to keep track of initial and revised goals agreed on with the client. It's useful to revise these by using scaling questions. Not only do you need to ask the client these questions, but also yourself, on how close are you to achieving your goal.

Revising

"I want to ask you a slightly different question. Looking back, suppose when we first started that your life was at 1 and where you want your life to be is 10, where would you say you are now?"

"What do you suppose it will take for you to be at a 5 or 6?"

"On the same scale where 10 means you have every confidence that you will continue to control your drug use, 1 means you have no confidence at all, where would you say you are today?"

Assessing Readiness

T- "You've made a lot of changes since we started to work together. On a confidence scale of 1-10, 10 being you have every confidence and 1 being you have no confidence at all, where would you put yourself now?"
C- "I would say I'm at a 7"

T- "I think it takes some getting used to the changes you have made. What would it take for you to stay a 7 for the next month? Two months?" "What would . . . . . . say it would take for you to stay at 7?"

Asking the client about confidence in maintaining change gives a good indication of how integrated into his/her life s/he sees his/her new behaviour, and often allows his/her to specify clearly what she needs to do to maintain this.

**Initiating Termination**

When initiating termination, it may be useful to consider the following questions:

1. How does the client understand what they did to find solutions to the problem? Do they have a clear sense of what they did to help themselves?

2. Is this something that can be applied to other situations?

3. Do they have clear ideas on what may be the early signs that things have started to deteriorate? Do they know what to do if it were to happen? (Berg 1991 p135*)

Once the client is confident that the goal has been achieved and that the changes involved are likely to continue, then both therapist and client can know that they can stop meeting.

* Dolan, Y. M.  *A Path With A Heart* New York Brunner & Mazel 1985

* de Shazer, S.  *Clues* New York Norton 1988


N. B.  *Life is full of problems to be solved, if you wait till all the client's problems are solved, it could be endless. What is important is that "empowering clients" means equipping clients with the tools to solve their own problems as far as possible. It may be that termination can occur when you are confident that the client will know when, where and how to solve his/her problems or seek help, not when you are confident they will have no more problems.*
If you are stuck with a client, here are things to consider:

_Goals, Goals, Goals._

What are the client's goals? If you don't know, they can be re-established by asking:

- Scaling questions, using 10 as "where the client would like their life to be".
- A variation of the Miracle Question (eg "Let's suppose the therapy is successful and in six months time you send me a post-card telling me your life is back on track. In that card what things would you tell me were happening in your life?")
- "What else needs to happen here so you can regard the therapy as successful?"
- Or simply: "How can I be helpful to you?" or "What do you think we should talk about today?"
- Admit that you think the counselling is not going well: "I have a feeling that the counselling is not helping you, so I'm wondering what you think needs to happen here to help you solve your problems?"
- If the client has been in previous counselling: "Was the counselling you received helpful?" If yes ask "How?" and do likewise.

_Reconsider Visitor, Complainant, Customer._

Are you trying to make a customer out of a complainant or a visitor? A sure sign of this is that you want the client to do something and they are not interested. Ask yourself what are your goals for this client. Are they the same as the client's goals?

_If YOU are an Absolute Customer to your Client Doing Something._

If you are convinced that a client should do something, for example: leave their marriage, have an abortion, confront their child, take the perpetrator to court etc and you feel this must be discussed, here is the way we would do it: "I've been thinking a lot about your situation and I can't help thinking that doing ________ would really help you. What do you think about doing that?" "How do you think doing ________ would help you?"
Do Something Different: The Client.

Comment that "What you've done up till now doesn't seem to be making things better. So what other things have you considered doing?" or "What things have others suggested?" or "What other things would ______ (a person respected by the client) do in your situation?". or for someone who has another role in their life, for example a mother who has problems with her son and is also a teacher: "If you were teaching John and he wasn't your son how would you deal with him?"

Give a "Do something different task". This of course requires a customer relationship between the therapist and client.

Do Something Different: The Therapist/Case worker.

If you've tried all of the above and nothing's changed it's time for you (the therapist/case worker) to do something different. If there has been no improvement by the middle of the third session we start this process:

- **Be quiet and listen:** Ask the client "Is there anything you feel I need to know about your situation that we haven't talked about?" Then be quiet and listen for their language and their goals. You may have to draw out their story over 10, 20, 30 minutes before you get some sense of what they want. Once you have something to go on ,check it out with the client: "It seems to me what you really want is ______. Is that right?" If yes: "How would that make a difference to you?"

- **Split people up:** If you are seeing more than one person see them separately.

- **Ask someone else to come in:** If someone else is involved, ask if they would come in.

- **Change the Therapist:** Here, after the therapist admits s/he doesn't feel they are being helpful, another member of the team takes over. Alternatively, we may simply ask for another therapist to join us in the room or behind the mirror. Another variation on this theme is to record the next session and go back over it and/or get another professional to go over the tape.
• *Change the time, the chairs anything!.* Change the room you use, change the chairs you use, change the time you see the client.

• *If none of the above works:* Change your model of therapy/intervention.

*Always remember that Solution Focused Brief Therapy is a model of therapy that 'privileges goals'. For a small proportion of cases (an informal study in Milwaukee estimated this at about 5 percent) the therapist and the client will be unable to identify a goal, but the client keeps coming to counselling. If you are to continue with this sort of client you may well need another model of therapy.*
COPING QUESTIONS

Sometimes therapists will run into cases where a client has experienced extreme deprivation, disillusionment or has a personal history that is fraught with high risk of abuse, or mental illness. Often these clients are those with a hopeless view of themselves and their futures and may believe that their life will not improve no matter what they do.

This kind of client cannot be comforted or reassured that there is hope for them. Many professionals feel that the most difficult clients are those with a hopeless view of themselves and their futures.

When faced with such a clinical situation, coping questions can be successful in challenging the client's belief system and feelings of hopelessness while at the same time orienting them toward a sense of a small measure of success. The goal for the worker is to help the client discover their own resources and the strengths they did not know they had.

Example One:

T- "Having heard about your terrible experience and your family's drinking history and all your mother has said about you, it is understandable why you believe that nothing will help. So tell me, how do you keep going everyday? How do you even manage to get up in the morning?"

C- "I don't get up every day like I should."

T- "So, how did you manage to get up this morning?" (with a look of amazement)

C- "I forced myself because the baby was crying."

T- "I can imagine how tempting it would have been to just give up. What did you do to get up and feed your baby?"

C- "I love my baby. I had to get up. I don't want her to be hungry."

T- "You must love your baby very much. You're a loving mother aren't you?"

C- "Well it's the only thing that keeps me going."

Here the therapist accepts the client's world view and goes beyond it by forcing her to come up with her own reason for continuing in life. The therapist's next task is to expand and build on this.
T- "So, what would it take for you to keep doing what you've been doing?"

Example Two:

T- "I'm confused Lisa. From what you've said so far, most people would find their lives a lot worse than what you have, given the same set of circumstances. How come things aren't worse? What are you doing to keep them from getting worse?"

C- "You think so?"

T- "Yeh, I sure do. Tell me again, what are you doing so that things are not worse?"

C- "I keep reciting my serenity prayer and keep the spiritual side to my life."

T- "That's a lot. How did you figure out that doing this would help?"

C- "There are lots of things I learn't in AA. I forget to use them."

T- "So what do you need to do so that you can continue to remember to use these things?"

This variation of the coping question asks: "How come your life is not worse?" and is used to 'blame' the client for her success which she does not see.

Coping questions can be very useful when helping a client in acute crisis. Rather than reassuring the client that s/he has survived the trauma, the use of these questions uncovers and then utilizes what the client did to survive the crisis or trauma. The emphasis in such a situation is on conveying to the client that s/he somehow managed to survive the crisis and not make things worse.
# First Session Worksheet

**Name**  
Date  

**Problem**

**Miracle Question**

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th>Compliments</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Part of Miracle**

**Scales**

<table>
<thead>
<tr>
<th>Progress #</th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Step</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Presence of step</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Willingness #</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Step</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Presence of step</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

© Centre-care Brief Therapy Service
AMPLICATION DIALOGUE (EAR)

Elicit - What's better?, What's been different, What's gone well?

| Amplify - What did you do to make that happen? How did you do that? |
| Reinforce - Wow! Not everyone can do that. |
| Start Over - What else has been better? |

SCALES

| Progress #: |
| Step: |
| Presence of step: |
| Confidence #: |
| Step: |
| Presence of step: |

© Centrecare Brief Therapy Service
### WHEN NOT BETTER

Have there been times when the problem could have happened but didn't?  
How have you managed to keep things okay?  
How can we help today?

### ANYTHING ELSE?

### MESSAGE

Compliments -

Bridge-

Task -
Solution Focused Brief Therapy: Selected Bibliography plus notes ... 


- Easy to read application of the Solution Focused model to a wide variety of cases and a clear articulation of step by step use of the model.


- Good articulation of what to do in second and subsequent sessions which many therapists are unsure of in this model.


- Excellent and very practical article on how to work with children and teenagers when the case worker/therapist sees them on their own. Kral has written many articles regarding the application of SFBT to schools work.


- Good summary article, particularly regarding pre-session change and exceptions.


- Excellent description of the application of Solution Focused approach to child protection work, explained through one detailed case study.


- Clear description of the application of Solution Focused approach to group work. Detailed description of a six week program.

Weiner-Davis M. Divorce Busting Summit Books New York 1992

- The first Solution Focused self-help book, it focuses on marital issues. Very clear, with many case examples and is very useful for the practitioner also.

Family Therapy Case Studies is an excellent ongoing source of articles in the Brief Therapy and Solution Focused areas. Available from the Eastwood Family Therapy Centre PO Box 630 Epping NSW 2121 $25 for one years subscription.
Brief therapists need a quick and efficient way to interview children which can yield information useful for this style of working. The QIK represents an attempt to develop a “standardised” interview which is both understandable to kids and able to offer data for intervention. The process is described along with a discussion of the rationale behind it. An example of an interview with a student is provided for clarification.

As a school psychologist and family therapist who works primarily with children and teens, I am often called upon to “find out what is going on with a young person”. While it may be obvious that the interactional patterns between the adults and this child are the problem, most adults prefer that the ‘expert opinion’ be based on face-to-face contact with the problem child. So, I can find myself interviewing students in order to develop credibility with adults. Not an uncommon situation for most clinicians, but what should that interview be? And, more importantly, what can be accomplished with the child/teen? These were questions which I often asked myself, so I began to review what I had done in this regard over the last years.

For a period of time I simply asked about the interests, likes and dislikes of the individual and found myself with predictable and usually unenlightening answers like, “I like doggies”, or “I just hang around with my friends”. The information was not very helpful and the impression I left with the child was that I was some guy who asked the same stupid questions which most old people asked when they had to spend some time with kids. That did not seem like a good way to leave the door open for further work later.

Next I got “psychological”. I would inquire about “3 Wishes” or what type of animal which the child would be if he/she could be any type of animal and why. Many responses were cute, but I couldn’t tell what were the implications of wanting to be a horse as opposed to a zebra. And snakes completely baffled me. I did leave the room having the kid confused...
and that was some improvement. Now I was not just any old person, I was a fairly weird old fellow. This way, at least, I had a few options in the event we met again. I could do just about anything, but I had not set much expectation for change.

Finally, I decided to operationalize a number of different ideas in the context of working with teens and children. First, the interaction should help set the stage, both in terms of expectation and data, for the “5 ‘D’ Solution Process” for Solution Focused Brief Therapy” (Kral, 1988). This process is a “shorthand” method of applying the basic principles and techniques of the Solution Focused Brief Therapy model of de Shazer (1985, 1988). This would require learning something about the child’s view of a solution, his/her view of the world, possible goals, actual exceptions to the problem behaviour and some idea of what to do next. This can be a tall order for an adult and an impossibility for a child could understand needed to be developed. This schema would need to be flexible enough to adjust to each child’s unique situation, yet concrete enough so that the child could understand and follow the questions.

To tackle this problem, the ideas presented in Kowalski and Kral (1989) on scaling techniques appeared to come in handy (also see Lichik, 1988). What appeared to be necessary was to transform a child or teen’s experience into a numerical scale which then could be manipulated and translated back into either a concrete example or an expectation. So scaling was added to operationalize the concepts from the “5 ‘D’ Process”.

Ultimately a set of semi-structured questions was developed and informally field tested in my practice in the public schools and private clinic. Once I found a series of questions which seemed to meet my requirements, I shared them with several groups of school counsellors and psychologists. I received positive feedback from these other professionals regarding the interview including a few anecdotes of “successful stories”. The very strength of the technique: adaptability to individual situations and its ability to assist the therapist in the process of creating elements for change, however, made it difficult to test empirically. It is not standardized in the sense of norms, nor is it analysed to offer “profiles” or “cutting score” to categorize problems or individuals. It does, however, seem useful in understanding and, more powerfully, in creating the possibility of change in child/teen centered cases.

The Q.I.K.

As with any technique one of the requirements for success with the QIK is flexible administration and interpretation. The interaction with your client and the acquisition of useful information outweigh “doing it right”. Therefore, what follows are general versions of the questions which can be altered on elaborated on as needed in each case.

**Question 1:** “Think about the best person (student, brother/sister, friend, worker, etc.) you could be — the ideal you. Make sure it is possible (realism is important here, a boy can’t wish to be a girl or a 4’11” child can’t hope to be 6’2”, etc.) and give that person 100 points. Now, tell me how many points you would give yourself these days.”

This question provides an estimate of “self-concept” in the sense of a client’s feelings of “measuring up” to some standard. It is self-anchored in the sense that the therapist has no idea of what the numbers represent at this point. An informal survey with adults, however, suggests that the most “normal” people rate themselves anywhere from 70 to 85.

**Question 2:** “On a scale of 1 to 10 now rate how much you like (or how satisfied you are with) your rating on the previous 1 to 100 scale.”

The second question is more like “self-esteem”. While you can have a certain concept or rating of yourself, your opinion
or value of that may vary. Kids that are highly satisfied may not be good “customers” (de Shazer, 1988, p.89) since they tend to be satisfied with the status quo. This, however, can only be a guess or working hypothesis which will need to be tested later. The question does, though, provide a sense of initial investment.

**Question 3:** “When you move from ‘60 to 70’ (or ‘85 to 90’, etc.) what will be different which will tell you that things have changed? … Have you been at ‘70’ (or ‘90’, or …) before, and if so what was happening then? … What is the highest you have ever been on the scale? When — what was going on then?

**Question 4:** What are the chances that you could … (do the exception) … again (or now)?

**Case example**

Darcia, a 17 year old girl, was referred to me by her school counsellor. He, along with Darcia’s mum, were concerned about possible depression. Darcia’s father and mother, were both diagnosed as clinically depressed and were taking medication. Her mum was involved in counselling, but her father refused to go. The school counselor reported that Darcia was performing well in school and had
not been interested in services from him for her "depression". Rather than "discharging" her, he wanted a "second opinion" that the girl either needed service or was "well enough" to make it on her own. Darcia was seen by me on one occasion and a consultation was held with both the counsellor and the girl's mother.

In response to the first question, Darcia rated herself as an '85'. In discussing this a bit she shared that she was earning all B and C grades, was positively involved in a church youth group, had friends both in school and her neighbourhood and got along reasonably well with her younger sister. It is not always necessary or useful to have the client elaborate on the initial rating, but with time permitting it can provide a broader picture of her "world view".

The satisfaction question yielded a '5'. She was moderately pleased with her '85' rating. This offered a hypothesis that she either set high standards for herself (in comparison to the suspected '70 to 85 norm') or that '85' was simply not good enough for her.

When asked what will (the word "will" is deliberately chosen to introduce an expectation of future change — see O'Hanlon, 1987, pp. 199-222) be different when the '85' moves up to '90', Darcia initially answered that she would "cope" better. With further behavioural questions, she finally concluded that she wouldn't "pop off" at her dad when he did something silly, stupid or irritating. Instead, she would either just go along with what he said or "count to 10" in her head and remember that he was just acting "foolish". She was then asked to describe those times WHEN it was '90 ALREADY. Darcia was able to list a large number of incidents, all of which occurred at school, out with friends or at church. She could not think of a time when she was '90' around her father.

Finally, her probability rating of moving to a '90' around her dad was described as "Oh, I don't think I could ever do that!"

Placing the data from the QIK into the framework of the '5D' thinking, the following chart could be developed. (see Figure 1).

<table>
<thead>
<tr>
<th>Develop a solution</th>
<th>Darcia indicated that she would be able to &quot;cope better&quot;, primarily around her father. She had friends, participated in church activities and she did well with her classes.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Discover exceptions</td>
<td>Darcia described '90' behaviour at times other than when she was with her father. She also could state that &quot;not popping off at dad&quot; would appear to be a logical next step.</td>
</tr>
<tr>
<td>Describe thoughts, feelings, actions</td>
<td>Darcia seemed to see her father's &quot;mental illness&quot; as an insurmountable problem for her. A different frame within which to view it along with &quot;counting 1 to 10&quot; when he irritated her could be quite helpful.</td>
</tr>
<tr>
<td>Doing something more of the same</td>
<td>Keep up with friends, school, church group</td>
</tr>
<tr>
<td>Doing something different</td>
<td>Try: &quot;Avoid Urge&quot; Task (de Shazer and Molnar, 1984) &quot;Externalizing 'Depression' as pushing her around&quot; (White, 1989) &quot;Normalize as stress related&quot; (O'Hanlon and Wiener-Davis, 1989)</td>
</tr>
</tbody>
</table>

Figure 1: Placing the data from Q.I.K. into the framework of the '5 D' solution process (Kral, 1988)
Case Studies

Conclusion

From the chart a number of possible intervention strategies could be developed along with a different sense of Darcia’s situation than a more traditional psychological interview would have yielded. Variations in questions to include Darcia’s impressions of how her mum or dad might rate her could have been included to help further clarify the interactional elements of her situation. What is clear, however, is that the specific questions are of relatively limited importance. The crucial skill is to develop useful SEQUENCES of questions to collect appropriate data to create change (see Lipchik, 1988 for further treatment of the technique of interviewing).

With a little practice the QIK can add a little extra to the “bag of tricks” which other Brief Therapists can take with them into the consulting room when they are working with children and/or teens.

References


