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Orienting Toward Solution: How to Interview for a Change

> "I never learn anything talking. I only learn things when I ask questions."
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> —Lou Holtz, *The New York Times*

> A young man wanted clear statements about Erickson's method. Erickson interrupted the discussion and took the man outside. He pointed up the street and asked what he saw. Puzzled, he replied that he saw a street. Erickson pointed to the trees that lined the street. "Do you notice anything about the trees?" The young man eventually noted that they were all leaning in an easterly direction. "That's right, all except one. That second one from the end is leaning in a westerly direction. There's always an exception."
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> —Jay Haley, *Advanced Techniques of Hypnosis and Therapy* (1967)

SOME YEARS AGO, WE DECIDED TO SENSITIZE a group of beginning therapists to the process of solution-focused interviewing by showing them a videotape of a family interview. The family on the tape were actually neighbors of ours who had volunteered to come to our Center to have a videotape made of a typical family meeting. The purpose of the meeting was to plan an upcoming family picnic. We asked the family members to be themselves as much as possible and then turned on the camera. The Kellys did their best to simulate their usual family interactions in planning the picnic.

We then showed the videotape of the Kelly family to the trainees with instructions to describe, *not explain*, what they observed. We purposefully withheld the information about the real purpose of the tape as well as any identifying information about the family.

Very quickly, trainees began to describe what they "saw." Some of the

students noticed that the mother was an "angry and controlling woman" who seemed frustrated in her marriage. Another group pointed out how the husband was distant and aloof because he seemed to them almost reluctant to be pulled into the family interactions. Almost every trainee saw a strong alliance between the mother and the children and saw this bond as being possibly causally related to signs of behavioral problems in the children. Signs of problem drinking were soon identified in the father, and the mother appeared, to the training group, to enable him in maintaining his distance from the family by taking over the management of the children. Some trainees even speculated about whether there was sexual abuse of the daughter. Evidence of this abuse was based on an interpretation of the way the daughter ignored the father's suggestions and instead sided with her mother. As the tape progressed, the group of students continued to find more and more evidence of pathology and problems in this family.

This experience was truly an eye-opening lesson for us about how easy it is to move from the simple description of an event to causal hypotheses and explanations. In reality, the Kellys are a well-functioning family that we know very well. The speculations made about the Kellys raised serious questions about how observers arrive at conclusions, verify the truth of their conclusions, and how such conclusions affect clinical work.

According to Einstein, believing is seeing. In other words, what we believe dictates both what we choose to see and what we choose to ignore. Just as in the videotape, though the family was normal, because the trainees believed there were problems and pathology they were able to find them. Such selective attention gives us the means to organize the information entering our senses in a logical and coherent fashion and is a normal process. Given this knowledge, however, we must be careful to bring balance to the pictures we construct about the people and families we work with. Certainly, our views will affect our judgments about those people and the nature of our interaction with them.

THE PURPOSEFUL INTERVIEW

Interviewing is a complex process. What is said, what is not said, how it is said, who said what about what, when, and how, all convey information between the client and the therapist. Communication flows in both directions (Weakland, 1991). What the therapist decides to ask, what she ignores, what she highlights, the inflection of the voice, facial ex-

pression, body postures, subtle and not-so-subtle nuances of tone, convey to the client what the therapist thinks is important and related to achieving the client's goals.

Views of the therapeutic interviewing process have undergone a tremendous shift in recent years. In the earlier days of Freudian training, the therapist was thought to be a "blank screen" onto which a client's psychopathology was projected. Therefore, it was important for the therapist to maintain his "objectivity" and remain "value free." However, beginning with such pioneers as Karen Horney and Harry Stack Sullivan (Horney, 1937; Sullivan, 1952, 1954), therapists began to see the interviewing process as an interactional relationship. This opened up a new view of how the therapist participates in the client's construction of problems and solutions to problems (Anderson & Goolishian, 1988; de Shazer & Berg, in press; Efran, Lukens, & Lukens, 1990; O'Hanlon & Wilk, 1987).

Currently, many thinkers view the interview as a "therapeutic conversation" in which the therapist actively participates in the process of defining what the problem is and how it is to be solved (Anderson & Goolishian, 1988; de Shazer & Berg, in press; Penn, 1985; Tomm, 1987a, 1987b; Weakland, 1991). In solution-focused therapy, the therapist and client join together to form a therapeutic unit based on mutual trust and cooperation. The conversation of the participants in this therapeutic system jointly constructs what is problematic to the client and how both the client and therapist will cooperate to find a solution to that problem. Since the interviewing process cannot help but influence the client's view of the problem or potential solution, a method of interviewing has been developed to influence the client's view of the problem in a manner that leads to solution. In this process, we have found five questions to be exceptionally useful in fostering conversations that lead to solutions.

FIVE USEFUL QUESTIONS

Each question the therapist asks conveys to the client what the therapist believes is important in accomplishing the treatment goals. We believe that the therapist must select questions that are useful in finding solutions to the client's problems. Notice that the questions a therapist asks a client are based on assumptions and beliefs about what will be helpful to the client. The types of questions used in the solution-focused interview are based on our assumption that the best way to help clients is to capitalize on their existing strengths and resources.

1. Questions That Highlight Pre-Session Change

As indicated in Chapter 1, one of the basic tenets of the solution-focused model is that changes occur constantly. And indeed, we frequently observe that clients have made changes in existing problem patterns prior to coming for their first session. So common are reports of pre-session change that we now routinely ask clients to watch for evidence of it when scheduling their first session.

Not infrequently, problem drinking clients have started their first session with comments like, "I was wondering if I should have come because since I made the phone call I am drinking much less" or "I don't know if I am doing the right thing. Maybe I am wasting your time." Rather than interpreting such positive, pre-session change as evidence that the client is "resistant," "in denial," or lacking the necessary commitment for treatment, we have found it useful to use such change as a building block for attaining future goals. This was certainly the case with a client seen recently at the Center:

Client: Since I called, I have cut down on my drinking because of a friend.
Therapist: Well, tell me more about that. What do you mean?
Cl: I drank all my life, all hard stuff. I got started in the army when there were cheap drinks from the PX. I drank all the time, man.
Th: So, how have you managed to cut down on your drinking since the phone call?
Cl: I haven't had anything hard to drink for two weeks now because of that friend.
Th: That is incredible. You didn't drink anything hard for two weeks? Sounds like this friend is really important to you.
Cl: She is. She wants me to stop completely.
Th: So how much are you drinking now?
Cl: As I said, I used to drink all hard stuff. A lot. Too much. I been drinking only beer now.
Th: You gave up hard liquor?
Cl: Yeah.
Th: Was it hard, I mean, not to drink?
Cl: Not really. When I am with Sally I don't drink at all. I only drink when I hang out with my brother and friends.
Th: So, what do you suppose Sally would say is different about you when you don't drink at all?
Cl: She would say I'm a different person. I don't have a bad attitude.

Studies do support our observation that clients make significant changes in their problem patterns prior to coming for treatment (Bloom, 1981; Kogan, 1957a, 1957b, 1957c; Noonan, 1973; Talmon, 1990; Weiner-Davis et al., 1987). Such changes, however, are rarely reported spontaneously by clients. For this reason, it is crucial that the therapist inquire about the existence of such changes! In his studies, Talmon (1990) found that when a therapist makes a point of asking clients about pre-session change nearly two-thirds of the clients report some sort of change. Moreover, such change is usually in the direction desired by the client.

We think a client who makes changes on her own needs to be encouraged; because when the client has made these changes, it is easy for her to take ownership of the solution to her problem drinking. When the therapist helps the client claim her own solutions, the client is more likely to maintain those goals. Frequently, it is a profoundly emotional experience for the problem drinker to take credit for the solutions, since it is rare that she is given recognition for success when it involves her drinking. In addition, since the solutions found are already natural to her way of doing things, the client is more likely to succeed in maintaining these solutions.

The first method of discovering if pre-session changes were made is to ask:

> "It is our experience that many people notice that things are better between the time they set up an appointment and the time they come in for the first session. Have you noticed such changes in your situation?"

This sets up an expectation and an assumption that it is quite normal and expected that their serious problems may have eased a bit since they made the appointment.

Client reactions are quite varied, as one can easily imagine. Some clients are clear that "things are a little bit better" but are not sure how much to trust such good fortune, and they wait for the professional opinion. Other clients are more cautious, because a change has happened before and then the problem usually became worse. Therefore, the client with such experience is still somewhat skeptical of how long lasting the improvement will be. She seems to be more hesitant, especially when the positive changes involve other members of the family. When the pre-session change involves her having taken active and deliberate steps she is more willing to trust such changes as indicative of a move in a positive direction. When the client is in a "complainant-type"

relationship, meaning the problem involves others (such as the spouse or children), she tends to be more skeptical of such changes having a lasting effect.

We both prefer the second method of investigating the pre-session changes. That is, instead of immediately asking a direct question about any pre-session changes, we find it less intrusive to wait for the right moment to ask about the pre-session changes. Not only is this approach more fluid and natural, but it also becomes a journey of discovery for both the client and the therapist. The following example illustrates this technique.

Case Example: After the Party

Therapist: So what would you like to have changed as a result of coming here today?

Client: Well, I'm not sure. I was just coming out of a bad state when I called you people. Maybe I just scared myself. I knew I was drinking too much. So I just cut out drinking altogether. It's been four days now and so far I seem to be doing it.

Th: So, how did you do that?

Cl: You know, I was just drinking too much and I had to do something.

Th: So, how did you manage not to drink for four full days?

Cl: One thing I did was I called here. Then I decided that if I'm going to be serious about it, I better start right then and there. So, I just stopped drinking.

Th: Is that different for you?

Cl: Yeah, it sure is. I am one of those people who believes in solving your own problems. But this is the first time I realized that I needed some help. It is really hard for me to accept help from anybody. That's why I can't go to A.A. I don't want to hear about other people's problems and I don't want to spill my guts to strangers.

Th: So, how did you manage not to drink for four days now?

Cl: It wasn't easy, I will tell you that. But it is getting easier.

Th: How did you get the idea of getting a head start on this? Some people drink more when they are getting ready for treatment. Are you the type who takes the bull by the horn and runs with it?

Cl: Well, I never thought of myself like that. But I always knew that I had to do something about my drinking, so I just decided it might as well be right now.

Th: So, suppose your wife was here—if I were to ask her what she noticed different about you, what do you suppose she would say that's been different about you these four days?
Cl: She probably would say that I'm more relaxed. I know I've been pretty jumpy lately.

The therapist empowers the client by asking more about the steps he took to arrive at this decision. Asking about other family member's perceptions not only verifies the information the client is giving the therapist, but it also directs the client to be aware of how his behavior affects others. The next step is to help the client find ways to maintain this sobriety he has started on his own.

Th: So, what do you have to do so that you can stay on this track?
Cl: I've been wondering about that myself. (Pause) I guess I will just have to keep doing what I've done for the past four days.
Th: So, what have you been doing for four days? That's a long time not to be drinking for you.
Cl: I just kept busy. Actually I've been feeling pretty good. Just knowing I'm doing something good for myself and my family helps a lot. It also helps to see that it makes my wife happy with me.

The therapist spent more time asking in detail about what the client needed to do to maintain this nondrinking life-style. At the end of the session, the client was given compliments and then had homework suggested to him in the following manner:

> "We are very struck by your determination to do what is good for you and your family even though it is tough to do. It is clear to us that you are the kind of person that will solve problems your way and not follow the crowd. It is also clear that you are a man of action and when you make up your mind to do something, you take the bull by the horns and go with it.
>
> "Because you realize that you need to take one day at a time and be on guard [these are the client's words], and because you realize that you need to go slowly, we would like to have you keep track of all the things you are continuing to do in order to stay sober. You may even discover some new things you haven't tried yet."

When the client has found ways to take charge of his drinking, it is helpful for the therapist to give full credit to the client. This empowering process enhances the client's self-perceptions. When the client

owns up to the solution, it is easy for him to own up to the problems, too.

As you can see from this case, when there is a clear pre-session change in the direction the client sought help with, and when the client is confident of staying on course, the next step for the therapist is to help the client remain on the course that was started before the first session.

Each subsequent session is spent in reviewing and discovering any new changes the client makes, and how the family members react to these changes, and what needs to be modified in order to stay on course.

2. *Exception-Finding Questions: Enhancing Existing and Past Successes*

Just as we value the pre-session change as a context marker (O'Hanlon & Wilk, 1987), the exception to the problem needs to be pointed out and labeled as such by the therapist. This approach capitalizes and utilizes (Dolan, 1991) the client resources, thus enhancing the client's self-esteem.

An exception to a problem occurs when the client engages in non-drinking behavior, either spontaneously or by taking some concrete and measured steps. Therefore, when asked about an exception, some clients can describe in detail how they managed either to reduce their drinking or to abstain altogether by taking specific steps. For example, a client described her exception to problem drinking during the weekdays in the following manner:

Case Example: Deliberate Exceptions

Therapist: So, I am curious about your nondrinking days. How do you do it?

Client: I never thought about it like that before and so I'm not sure if I can tell you exactly.

Th: You mentioned that you don't drink on weekdays.

Cl: I haven't done that for years. How do I do it? I have to do it. I just make up my mind that I'm not going to touch any alcohol. Then I don't think about it. So, I tell myself it's not an option.

Th: Wow! That's amazing. How do you do that?

Cl: Don't give me all that much credit. I had to work very hard at it.

Th: That is even more amazing to me; that you worked so hard to be where you are at.

Cl: Sometimes, I get tempted when I'm out for parties or meetings and there is drinking. Then, I make sure that I only drink Coke, stay away from those who drink and concentrate on getting interested in people. I try to find at least one person to talk to and then just concentrate on their stories.

Th: That's amazing. How did you figure out that doing that helps?

Cl: It didn't come easy. I tried many things. I decided that I am going to concentrate on my career during the weekdays. In order to get ahead in my job, I have to put everything into it.

Th: I'm sure it's true. So, what do you do when you are home during the weekdays so that you don't drink?

Cl: I just concentrate on what I have to do: cooking, any homework, writing a letter or report, calling my friends, taking a bath, shopping, and all that needs my attention. I just remembered. I joined the health club. That really helps. I feel good about myself when I work out. When I feel good about myself I don't have to drink.

Th: What do you suppose your co-workers or friends would say they notice different about you when you are doing all those things?

Cl: I doubt that they even notice anything different about me. I told you that when I drink, I drink only on weekends and when I'm alone.

Th: I remember you did. So, what would it take for you to not drink on weekends also?

Cl: That's just it. (Pause) Well, I suppose I could pretend it's the same as weekdays. I will just have to have the same mindset I have on weekdays and maybe I should save some of my chores for the weekend. You know that is when I get bored and lonely. That's when I get in trouble. I should go work out on weekends, too. Actually, it will be good for me to be interested in life and not wallow in my sorrows on the weekend, too.

The client, an ambitious and attractive career woman, recognizes through this conversation that she manages her weekdays quite well. In the process of responding to the therapist's questions about what she does to not drink, the client becomes aware of all the activities that are part of her life. As she explains these activities to the therapist, she is beginning to construct her successful strategies for what to do on the weekends to avoid drinking. A client may need some help in this recounting (in a positive and helpful way) so that he will discover what he can repeat. For this client, the vulnerable points she identified were her

feelings of boredom and loneliness. Her solution was going to the health club on the weekend and getting "interested in life." Sometimes the solution is simple and within very easy reach of the client.

Sometimes it is clear to the client that there are times when he is able to curtail or refrain from drinking. However, when asked, the client is unable to describe or retrace the steps taken to abstain. The most common response is "I don't know, it just happened. I just woke up feeling good." Some clients attribute the exception to events that cannot be repeated regularly. For example, Darryl makes sure that he does not drink during Lent because of his religious beliefs and values. George never touches alcohol when he goes out to dinner with his boss, no matter what the circumstances. He explains that he is expected to not drink, and everyone at dinner drinks only mineral water, tea, or coffee. It has been that way ever since the company president first stopped drinking after his heart attack. George is not able to describe what he does during those times, except that he does not crave alcohol.

Because these clients are not able to describe the steps they take when there are exceptions to their drinking, or because the exception is perceived by them as being other-dependent, it is difficult to replicate. Therefore, these are not very useful exceptions. As will be described in Chapter 6 on solution-focused interventions, when the therapist is faced with such a situation, he may find a prediction task useful. In Chapter 6, we will describe more fully how this prediction task can be applied with clients who have spontaneous exceptions.

The solution-focused interviewing technique magnifies and enhances a client's successes through repeated emphasis on those few, but important, exceptions. When repeated often and examined in detail, the client's successes become more real to her. When the client can "see" her success and recognize that she has actually taken steps to implement it, she is forced to face the reality that she does know how to stop drinking. When the client recognizes this reality it can easily become a self-fulfilling prophecy.

3. *"Miracles Do Happen": Miracle Questions*

As mentioned throughout this book, the miracle question may be the most important question of the model. It orients the client to a future state when the problem is solved and he can start to savor the successful completion of therapy. The question may be phrased in the following manner.

"I want to ask you a slightly different question now. You will have to use your imagination for this one. Suppose you go home and go to bed tonight after today's session. While you are sleeping a miracle happens and the problem that brought you here is solved, just like that (snapping a finger). Since you were sleeping, you didn't know that this miracle happened. What do you suppose will be the first small thing that will indicate to you tomorrow morning that there has been a miracle overnight and the problem that brought you here is solved?"

Time and time again, the most incredible thing happens. A client starts to dream about an alternate reality and begins to have hope for himself. Then he begins to detail how his tomorrow will be different. As he continues, he begins to smile, his eyes begin to sparkle, he sits up straight, and actually seems to glow as he describes the changes he imagines.

Often, this is a powerful new experience for the client. When a client can project to the future and imagine a transformation of her painful, hurt, and damaged life into a more coherent, harmonious, and successful life, it is an empowering experience. We believe this is the most important gift a therapist can give to a client: hope and a vision of possibility. Clients respond by being hopeful about their lives and about themselves.

"First of all, I will have had a restful night and so I will wake up in a good mood and say 'good morning' to my wife. Maybe even give her a kiss and we may even hug each other. We may discuss what is coming up for the day. I will get up without a hangover and look forward to the day. I may even help my wife by making coffee, help the kids with their breakfast, send them off to school. Maybe even give my wife a chance to sleep late for half an hour. She will like that. And I will go off to work in a good mood."

"A miracle? A real miracle? You probably won't notice it until I come home because I leave for work before everybody gets up. Yeah, that's when it will show. I will be nicer to my family. I will treat my family like they should be treated. They will know because they won't be afraid of me. How can they tell? Well, I will be relaxed. That's it. I will be calm, talk in a calmer voice to them. I won't swear at them. But most of all, I won't be drinking."

"I'm not sure. I never thought about that. Boy, that's hard. My girlfriend will say I am cheerful, more ambitious about myself and not talk down about myself. Yeah, more upbeat generally. That's it. I will feel good about myself. I will go places, I mean, with my job. I'm at a dead-end job now but I would feel like I'm going someplace with my life."

"My boyfriend will stop drinking. No, before that, he will admit that he has a drinking problem and not brush it off as if it is nothing. I suppose when he does that, I won't nag him. Then, we won't fight all the time. Yeah, more peace and quiet. Like we used to be when we first met."

"A true miracle? I believe in miracles. But miracles come slow. So, I suppose the first thing is I will feel like caring about myself. Personal grooming, I would say. No, that's what my husband would say. I will feel like taking care of myself, get dressed in bright clothes, get my hair done. Get some exercise, get interested in gardening. Taking care of my children. That will be a big miracle."

"A miracle? I will win the lottery and quit working. Seriously, my husband will have a stable job and contribute to the family. He will laugh again. I will see his eyes twinkle and see smiles on his face. That will be a miracle in our house."

Even though it is labeled as a "miracle," by and large clients are amazingly realistic and down-to-earth about their picture of the "miracle day." When someone starts to enjoy a pipe-dream or a pie-in-the-sky dream, the therapist can gently bring him back to reality either with humor, or by normalizing his wish to win the lottery, to have a yacht, and to live in a castle. But most clients know that it is just a fantasy and quickly settle into painting a more realistic miracle.

What is amazing, from our clinical experience, is that "miracle pictures" are quite realistic, detailed, and achievable within the context of the client's life. Since the image is generated by the client, it fits naturally into his life-style and, consequently, is achievable. As with the exceptions to the problem, it is within the client's ability to perform the miracle. The miracle picture is most useful when it is described in detailed and measurable terms. Inner feelings generated by a miracle image should be described as an outward sign of the changes that will take place. Therefore, when the client answers: "I will feel better, more peaceful, more relaxed," he needs to convert those ideas into outward manifestations of internal changes. Another good question to ask is:

"Suppose you find this inner peace (or feel content with yourself, or you feel like your old self again) tomorrow after the miracle, what do you suppose you will notice different about you that will tell you that you have this peace?"

We believe that the client with a drinking problem needs some external signs of how her internal self is changing. Because a client has ignored and masked these internal emotional reactions to her environ-

ment for so long (with alcohol use), she needs to learn to connect her internal emotions with her behavioral manifestations, or her drinking patterns with the consequences.

The next step for the therapist is to take advantage of this miracle and start to implement this information. Implementation could be facilitated by utilizing a form of the following dialogue:

Therapist: So, when would you say was the last time when part of this miracle happened, even a little bit?
Client: I will have to say, it was two weeks ago.
Th: Tell me about that. What did you do to have a little bit of a miracle day?
Cl: I am not sure. I would say it was on the weekend. I decided that I've been pretty selfish and made up my mind to spend the day doing what my family wanted me to do for a long time. We cooked together, went for a walk, and went grocery shopping. It sounds silly but we really had a lot of fun. It was a good day. We even agreed that we should do more of those things.
Th: So, what would it take for you to continue to do what you started that day?
Cl: You know, now that I think about it, not much. Just schedule and do it.
Th: What do you suppose your family would say it would take for you to repeat this?
Cl: Umm, that' hard. My wife will probably say the same thing. We did it, so, we will just have to do it.
Th: What is the first step you will have to take?
Cl: I have taken the first step already by coming here. So, I guess I will have to take the second step. Just plan it and have the babysitter lined up and take my wife out for dinner and a movie.

If there is a pre-session change or past success to rely on, the miracle day can easily be implemented. Because it is within his repertoire of available behavioral resources, it is fairly easy to repeat the "exceptional day" in a step by step fashion. In order to show clients that this is possible, the therapist needs to ask for detailed information about a small segment of behavior they initiated.

When the client reports no past successful period or there is no exception to the problem, the next step for the therapist is to help the client to project success into the future. Again, detailed descriptions are useful.

Therapist: So, what do you suppose is the first small step you have to take to make a little bit of the miracle happen?
Client: That's tough. I suppose I will have to stop drinking.
Th: That sounds like a big step to me. What do you suppose has to come before that, something small you can do right away?
Cl: Feel good about myself first. I have to feel good about my work. I know I should do better on my job. I can't goof off any more.
Th: So, after the miracle, what would you do different about your job?
Cl: Well, I will come to work with a good attitude.
Th: What do you have to do so that you will come to work with a good attitude?
Cl: Stop blaming my parents. I guess I have to grow up and face the fact that I have to support myself.

The therapist reinforces the idea that the client is ultimately responsible for shaping her own future. Just sitting around and talking about what could be different is useless unless the client actually takes steps to make things happen.

Now that the client has the image of the "miracle" picture, it is time to turn him into a "miracle worker." The next step is to transform the small portion of the miracle into reality and to help the client imagine what will change in his life when he actually takes steps to make the miracle happen.

Cl: You know what my miracle is? Do you really want to know?
Th: Why not? It's a true miracle and the problem that brought you here is solved. What would be the first small sign to you that your problem is beginning to be solved?
Cl: Jerry will serve breakfast in bed. It is something I dreamed about as a child. To me it is so romantic. Yeah, I want more romance in my life. When we first got married, he used to do it. I was so happy in those days.
Th: So, pretend that a miracle happened and Jerry served you breakfast in bed one day. What do you suppose you would do that you are not doing right now?
Cl: I won't be so angry with him.
Th: What would you do instead of being angry?
Cl: I would encourage him to spend more time with his family, to go along when he visits them.
Th: What else?

Cl: I would be loving toward him. I will put the past behind us and go on with our life.
Th: What will you do different then?
Cl: I will show more interest in his work, and be more responsive when he approaches me sexually. I may even suggest we go to the movies together without the kids.
Th: So, when you take the first step, what do you suppose Jerry would say he notices different about you?
Cl: He will say I'm happier, smile more, am nicer to the kids, and more loving toward everybody.

Notice the questions the therapist asks are phrased in such a way that it is possible not only for a miracle to happen, but also for the client to behave differently. "When" the miracle happens, not "if" it happens is the way the question is stated. "What *would* you do differently?" is a question that will gradually change to "What *will* you do differently?" Repeated questions are also designed to elicit repeated answers. When clients repeat the answers to these questions in an affirmative way, it becomes their own idea to make these behavioral changes. Questions are phrased in such a way so as to elicit information as well as make a strong suggestion that the client start new and positive behavior, behavior that is likely to make the miracle a reality.

Professionals who have observed our clinical work comment frequently about how patient we are when we ask these questions. We truly believe that even though it may seem to slow things down at first, it ultimately has the effect of speeding things up.

Instead of asking for detailed information about a client's problem areas or past history, we believe that repetitive questions about potential solutions is more productive. These questions work as a cognitive rehearsal and help map out the details of a solution. The more a client repeats the successful outcome verbally, the more real it becomes to her.

4. *Scaling Questions*

There is magic in numbers. When the client is asked to put his problems, priorities, successes, emotional investments in relationships, and level of self-esteem on a numerical scale, it gives the therapist a much better assessment of the things he has to know. The following are some of the applications we have used that we find helpful in assessing the relationship. Again, as in all other questions the therapist asks, the

scaling questions are designed to inform the therapist and also are used to motivate, encourage, and enhance the change process.

Scaling questions can be used to assess the seriousness of the problem.

Therapist: Let's say, 10 means how you want your life to be when you solved the problem that brought you here, and 1 means how bad things were when you picked up the phone to set up an appointment, where would you say the problem is at today between 1 and 10?
Client: I would say it's at 3.
Th: What did you do to move up from 1 to 3 in such a short time?
Cl: I had to do it. My life was in shambles. My husband and I had a long talk.
Th: Is that unusual for you to have such a long talk?
Cl: The first time in years.
Th: What else have you done to go up from 1 to 3?
Cl: I also went to an Al-Anon meeting. I stopped going years ago. But I felt better.
Th: So, what would it take to go from 3 to 4?
Cl: I will have to detach myself more from Jason.

The following example illustrates how a client rates her investment in a relationship.

Therapist: Suppose 10 means you will do anything to keep this relationship with Lee, and 1 means you are just going to sit and wait for something to happen, where would you say you are at right now?
Client: I would say I'm at 9.
Th: Where do you suppose Lee would say he is at on the same scale?
Cl: That's hard. I would guess he would say at 2.
Th: You mean you are far more invested in this relationship than Lee is?
Cl: I guess so, now that I think about it.
Th: Where do you suppose he would say he is at, if I were to ask him?
Cl: I think he would say he is at 2, maybe 3.
Th: Where do you suppose he would say you are at, from his point of view?
Cl: He would say I'm at 10. He knows I love him more than he loves me. He tells me not to do that all the time.

Th: So, how do you explain that you love him so much more than he loves you?

Cl: I am beginning to wonder about that. Maybe because I'm afraid of the unknown? Because of the kids? I will have to think about that very hard.

These questions startled this client into thinking about the hopelessness and the one-sidedness of her "carrying the torch" of love for someone who is not reciprocating her love.

The evaluation for progress in treatment is an ongoing process and is monitored continuously throughout treatment. We find the scaling question useful in individualizing the treatment process because it helps the client take ownership of her treatment, by allowing her to take the responsibility of evaluating the process. Because the rate of progress in treatment is determined by the changes the client is making, it is appropriate that the client take the major burden of assessing her own progress. Also, because the client is the consumer of the professional service, we believe that she needs to be in charge of the rate of change she is making. When the client can assess her own progress, the therapist can better help her determine what might be the next step in the treatment process.

Therapist: Let's assume that when you first started therapy the problem that brought you here was at 1 and where you want to be after you finish here is 10, where would you say you are today, between 1 and 10?

Client: I would put myself at 4. I have a way to go yet.

Th: Okay. What would you say you have to do to move up from 4 to 5?

Cl: More time. Definitely more time. I have been at this point many times before. I have to go slow this time, to make sure that it sticks.

Th: I absolutely agree with you. So, how much time do you have to stay at 4 before you are ready to move up to 5?

Cl: I would say two months.

Th: Sounds reasonable. So, let's imagine that you have moved up to 5, two months from now. What do you suppose your family will notice different about you that will tell them you are at 5?

Cl: They will say I will be more responsible, will pay my bills, won't leave the kids alone, won't get kicked out of my apartment. Of course, it means I won't drink any more.

Th: Wow, that sounds like higher than 5 to me, more like 7 or 8 to me.
Cl: Yeah, I'm anxious to get going with my life. I'm so tired of all this mess. I want a normal life like everyone else.
Th: So, when you do all of these things, what would be different with you?
Cl: I will have more confidence in myself. I will look forward to getting up in the morning, will be a good mother to my kids, will see my family more often. I will have a normal life.

The therapist helps the client chart her future in the direction she wants. The more the client repeats what she wants during the conversation, the more convinced the client is that these goals are exactly what *she* wants for herself. This increases her motivation and her confidence that the change is something she can carry out and maintain.

Our view is that the client investment in treatment is not static, nor is it solely dependent on the client personality (Miller, 1985), rather, it is in a constant state of fluctuation and change. Client investment in recovery seems to fluctuate and change according to many variables that are beyond the control of treatment or the therapist. Continuous and periodic assessment that measures the changes in the client's progress provides the therapist with a useful sense of normal fluctuation. Periodic assessment also provides ways to accommodate and adapt therapeutic practices to the changes in the client; such monitoring allows the therapist to encourage the client to "hang in there" when she becomes discouraged. The following are examples of how to use scaling questions for assessment purposes.

Therapist: Suppose 10 means you will do anything to stop drinking, change your life around, and do what is good for you and 1 means all you are willing to do is to sit and pray, where would you say you are at today?
Client: I have tried to sit and pray before and it doesn't work. I will say I'm at 5 because I have been at this for three months and that's the longest period of sobriety I have had so far.
Th: So, you've come a long way. What do you have to do next for you to move up from 5 to 6?
Cl: Just stay at this space longer, maybe like another month.
Th: So, if I were to ask your children and if they could verbalize things to you, what do you suppose your children would say they notice different about you that will tell them that you have moved up one more point?

Cl: They will say that I am more cheerful, more loving toward them. More dependable. I will be there when I say I will be there. They will really like that.
Th: What about your mother, what would she say she will notice different about you when you go up from 5 to 6?
Cl: She will say that she will get her old daughter back. I was a very responsible and nurturing person before I started drinking so much.
Th: Who else would notice the difference in you when you are at 6?
Cl: My ex-husband, probably. He will say I won't blame him for everything and will take ownership of my own problems.
Th: So, when you do that, what do you suppose these people will do different with you?

Alcohol problems affect all facets of the client's life. Therefore, most clinicians meet clients who seem to have so many problems (marital, financial, health) that it seems impossible to sort out what must be done first.

If a therapist can become overwhelmed by the long list of problems, it is not difficult to imagine how the client can be immobilized by them. It is crucial that the therapist provide the client with ways to organize his priorities. We find the following method useful.

Th: I realize that it may be difficult to put numbers on all of your problems. Suppose I ask you to put numbers on each of the problems we discussed. Say, 10 is the most urgent and 1 the least. Where do you suppose you will put the drinking problem? Problem with the marriage? The kids? Money? Health? In-laws? What number would you give to each of these problems?
Cl: I would say the problem with my daughter's running away, that's 10. I know it has to do with me and my wife fighting. But we have to straighten out Heather's school problem before we do anything. She has to finish high school and she doesn't have much time to mess with.
Th: So, what do you suppose Heather would say how important it is for her to finish high school? On the same scale, where do you suppose she would say she is on the school problem?
Cl: She probably would say she is on 5. Heather would say, though, our fighting is at 10.
Th: What do you suppose Heather would say will be different when you two stop fighting?
Cl: She would probably say that if we stop fighting she can do her

school work better. She just hates it when we fight. That's when she runs away.

Th: So, what would it take for you and your wife not to fight?

Cl: I will have to cut down on my drinking. If I know it's going to help my daughter I'm willing to do it. I love my kids. She shouldn't throw her life away like I did.

Th: So, what would Heather say you can do to be more helpful to her so that she can finish high school?

Cl: She probably would say I have to stop fighting with my wife and stop drinking.

From this conversation it becomes clear that his daughter's success in life is more important than anything else at this time. It is more useful to go along with his goals for the stated purpose as an initial starting point. When the client recognizes that his drinking interferes with what he values the most—in this example, his daughter's completing high school—it will be easier for him to stop drinking *because of his daughter* and not because he is an "alcoholic." Therefore, *not drinking* becomes a means to being a good parent. His willingness to consider what is good for his daughter certainly is the beginning motivation and it may change as he realizes what other positive changes will follow.

The application of the scaling question to the assessment of self-esteem was first described to us by a talented therapist, Ron Kral (Kral, 1988), in his work with children in school settings. Since then, we have adapted this to working with adults as well as children.

Therapist: Let's say, Tracy, that number 100 stands for the ideal person you always wanted to be, you know, the kind of person you always dreamed about becoming. How close are you to being at 100 right now?

Tracy: Well, I would say I'm at 25 today. I feel very low about myself today.

Th: So, what would you say was the highest number you have ever reached close to 100?

T: I would say about 50. That was the best or the highest I have ever accomplished so far in my life.

Th: That's pretty good, considering all the tough breaks you have had in your life. But how did you do that?

T: That was when I was going to A.A., I didn't drink for a long time, had a steady job, I felt like I was going somewhere in life. That was three years ago.

Th: What else was going on in your life, then?
T: I was involved in a relationship. I had reason to live. I was making progress in life.
Th: So, what would it take for you to be at 50 again? Since you did it once only three years ago, it means you can do it again.
T: I never thought of it like that. I suppose the first thing is to start to going to A.A. meetings again.
Th: Okay. What comes after that?

The fact that the client was at the halfway point one time in her life becomes an exception to her view that she has messed up her entire life. Remembering and describing what she did to be at the halfway mark give clues on what she needs to do (i.e., start attending A.A. meetings). This question not only gives the therapist some sense of how the client evaluates her own goal, but it also points out the exceptions and possible solutions as realistic and achievable.

5. *Coping Questions*

In consulting and supervision sessions with therapists, we find that many professionals feel that the most difficult clients are those with hopeless views of themselves and their futures. This kind of client cannot be comforted and/or reassured that there is hope for him. This client is often described by clinicians as a "very depressed and very depressing" type of person to treat. The therapist often dreads the sessions, secretly hopes the client will fail to show up, blames the client or attaches serious-sounding diagnostic labels, or keeps trying to reassure him again and again without success. As a result, the therapist may end up feeling as hopeless as the client does.

On the client's part, she may claim that there is no hope of her ever stopping drinking, or that her life will not improve no matter what she tries. This client's rationale is that because life is not likely to improve, why not just "drink life away and suffer in quiet desperation."

Of course, any client with this much of a pessimistic outlook is difficult for a therapist to face because it is exactly the opposite of what most therapists believe about their work and their clients. The therapist's most frequent reaction is that such a client "has to hit bottom" before he will accept that he has a drinking problem. It is a difficult notion to contemplate—that not every client can be helped regardless of what treatment model is used. Before giving up on this type of case, we suggest that a therapist try one other type of question.

When faced with such a discouraging clinical situation, we find that coping questions are often successful in gently challenging the client's belief system and her feelings of hopelessness while, at the same time, orienting her toward a sense of a small measure of success.

Therapist: Having heard about your terrible experience and your family's drinking history, it is understandable why you believe that nothing will help. So, tell me, *how* do you keep going everyday?

Client: I barely survive. You know about my history. Nothing will change. I will never be different. I will be like this for the rest of my life. It is sickening to think that I'm doomed to live like this for the rest of my life.

Th: So, how do you manage to keep going? (with a look of curiosity and *amazement*)

Cl: I keep telling you that I just live from day to day with no hope of my life improving.

Th: I can see why you believe that. So, what do you do to barely cope from day to day?

Cl: I drink. That's how I do it. What's the use? There is no hope for me. Coming from the kind of family I come from, nothing will change. It was hammered into my head that I will not amount to anything.

Th: I'm not sure if I agree with that, but, that's beside the point. So, what do you do so that you get through each day? How did you manage to get up in the morning?

Cl: I have to, don't I? I force myself to get up and barely get myself to work. It's an effort. I shouldn't have to do this. Life should be a joy. I should be glad to get up in the morning and look forward to the day.

Th: I agree. Absolutely. So, how do you force yourself to get out of bed and get to work every morning? I am amazed, considering what you have been through, the abuse, the alcoholic parents, no nurturing, and all the hell you've been through, I sometimes wonder how you manage to keep going everyday.

Cl: It's really no big deal. I just force myself to get out of bed and think of all those people who depend on me. I haven't missed a day's work this year yet. I rarely use my sick days.

Th: That's what I mean. How do you do that? I know a lot of people who have difficulty getting to work on time even without your background.

Cl: Well, you make it sound like it's a big thing. I just do it.

Th: You mean, you are the type of person who makes up her mind and then just does it?
Cl: Not because I enjoy it, but because I have to; I just do it.
Th: That's great.

The client is asked to describe *how* she "barely copes" with such a serious lifelong problem, she begins to describe a small step that enables her to get through each day. Clearly this small "barely coping," step she takes each day becomes the foundation for what she needs to continue to do.

However small it may seem, the small things the client does to "barely cope" are the very things that the client must do more of "one day at a time" in order to create a basis on which to build more successful measures. Such a client needs to be reminded and encouraged to barely cope. It is true that she deserves to enjoy her life more, but that comes later. The first step is for the client to recognize that she has coping skills.

Clients frequently are surprised when we ask this question. Their common nonverbal expressions convey a message of "You've gotta be kidding" and then they slowly begin to recognize their inner strength and resources. Here is an example of this recognition:

Therapist: I'm confused, Lisa, from what you have said so far, most people would find their lives a lot worse than what you have, given the same set of circumstances. How comes things aren't worse? What are you doing to keep them from getting worse?
Client: You think so?
Th: Yeah, I sure do. Tell me again, what are you doing so that things are not worse?
Cl: I keep reciting the Serenity Prayer and keep the spiritual side to my life. I try to remember things to be grateful for every day.
Th: That's a lot. How did you figure out that doing this would help?
Cl: These are the things that I learned in A.A. I forget to use them, though.
Th: So, what do you need to do so that you can continue to remember to use these things?
Cl: I will post the Twelve Steps on my refrigerator door. I have all those pictures my kids drew. I will make room for it.

As the above example shows, the variation on the coping question of asking, "How come your life is not worse?" is used to "blame" the client for her success which she does not see. Such positive "blame," as de-

scribed by Kral in his work with children and teachers in a school setting (Kral, 1988) assigns the responsibility of the positive or helpful behaviors to the client. It is used not only to affirm what the client is doing as being successful, but also indicates to the client that the therapist has confidence that she knows what she needs to do to solve her own problems.

We find the coping question very useful when treating a client in acute crisis. Before hastily reassuring the client that he has survived the trauma (which can range from a physical assault to a natural disaster), the use of a coping question 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 she somehow survived the crisis and managed not to make things worse. We have used this coping question strategy in crisis debriefing with success.

Case Example: Homicide Before Breakfast

Early one morning a man called the office asking to be seen as soon as possible. He indicated on the phone that he had nearly killed his wife and himself and that he needed to see someone right away. He sounded tearful and was in a great deal of emotional distress. We agreed to see him as soon as he could get to our office.

Sean, a factory worker, had had "on again, off again" marital problems because of his wife's drinking. The combination of his unstable job history and his wife's drinking caused considerable tension in the marriage and long-standing financial difficulties. Sean had also accused his wife, Connie, of having an affair, which she repeatedly denied.

The night before we saw him, Sean had returned home unexpectedly early from his "graveyard shift" only to find Connie and his best friend in his bed. He reported that his immediate impulse had been to grab his shotgun and shoot both them and himself but somehow he managed to control himself and ran out of the house—he had been afraid to return home since. His fear was what he might do out of rage more than what he might find at home. Instead, he reported that he had been "walking the streets" all night and called our office when he thought it would open.

It would have been easy for the therapist to focus on his rage, how he may have contributed to Connie's drinking problem, the marital tension, lack of money, and a host of problems that were apparent. The therapist realized that in the state Sean was in, what he needed was crisis management.

Therapist: Let's see. It is now a little after eight o'clock and you are saying this happened around one o'clock. So, what have you been doing since one o'clock to cope with this?

Sean: I have been walking the streets. That's the only way I managed not to kill anyone, including myself.

Th: You mean, you've been walking for seven hours?

S: Yeah, I couldn't go back there. I knew I saw red and I would do something I shouldn't do.

Th: So, how did you know that you had to leave the house? What gave you the idea to leave and not get into an argument with Connie or with Jim (his best friend)?

S: I know my temper. I just knew I had to get out of there. I couldn't sit down. I had to walk. I've walked everywhere, all over town.

Th: I'm still amazed you had enough sense to know that you had to get out of there. How did you do that?

S: I just knew it. Something inside me told me that if I stayed there, I would do something terrible.

Th: So, even in such a situation you had enough sense to listen to yourself. Did you know that about yourself?

S: To tell you the truth, no, I didn't know that. I always had a temper since I was young and that got me into a lot of fights.

Th: So, how did you know that you had to run out of the house when you did?

S: I thought about my kids. That's what I did. I didn't want my kids to grow up without their mother or father. It would break my heart . . . to see my kids get hurt from anything I do that is stupid.

Th: If I were to ask your wife, what do you suppose she would say you did that was most helpful?

S: She probably would say that I left. She is scared of my temper. She has always told me that the kids shouldn't see me lose my temper. So, I guess she would say that helped. But I don't know what I am going to do about this mess. I have to go home sooner or later and face the problem. I can't wander the streets any more. I have to find a solution to this problem.

Th: So, suppose a miracle happened while you were walking around all night and the problem that brought you here is solved. What do you suppose you will notice yourself doing differently?

S: First of all, I will handle myself calmer and use my head. I will sit down with Connie and talk to her, ask her, and not tell her what she wants to do about her drinking problem.

Th: What do you suppose she will notice different about you that will tell her that a miracle happened?

The client certainly did the right thing by running out of the house. His concern for his children became the important point to compliment the client on and became the focus for what his next steps would be. Because he took the right beginning steps, the next therapeutic task is to assess and plan subsequent steps in achieving his goal. The miracle question would indicate his ideas of how his life would be different when the problem is solved. The use of scaling questions would indicate how willing he or his wife are to solve this serious marital problem. Since the client is beginning to identify his temper and Connie's drinking as the important factors in their marital problem, the assessment of which problems must be solved first and who is willing to take what steps first can be negotiated through various questions.

The Therapist's Stance in Using These Five Useful Questions

The most striking comments and reactions therapists have when they observe our clinical interview is how the client responds to our repeated use of variations on these five useful questions during the single interview. At first, we were somewhat puzzled by these reactions. As we continued our dialogue and paid close attention to what the observers pointed out, it became more and more clear to us that our attitudes towards a client seemed to make the crucial difference. We are told that our respectful approach to the client and our genuine curiosity about what a client describes as her unique way of solving problems seem to make it impossible for the client to object to repeated questions. Frankly, we believe that the more the client is asked to repeat her success stories, the more convinced she will become that the solutions she implemented were exactly right for her. What better way for the therapist to empower a client to take control of her life and to solve her drinking problem?

At this point in the interview, it should become fairly easy for the therapist to assess the client-therapist relationship we described in Chapter 2. Depending on how willing the therapist is to negotiate goals with the client, the nature of the relationship changes dramatically. By reviewing what is most salient to the client, and how willing the client is to take the first small but significant step toward solving his problem, it becomes relatively easy to assess what that first step should be.