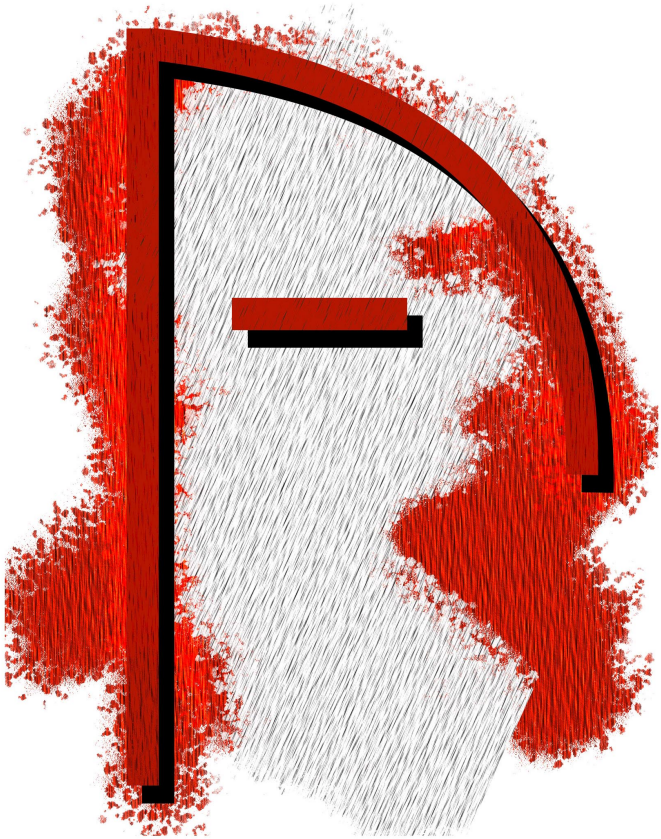

Solution-Focused Brief Therapy

Andrew Turnell & Larry Hopwood

Part 3. Beyond the first few sesssions - Ideas for 'stuck' cases & case closure

SOLUTION-FOCUSED BRIEF THERAPY: III. Beyond the first few sessions — Ideas for 'stuck' cases and case closure†

Andrew Turnell * and Larry Hopwood**

Solution-Focused Brief Therapy has become very popular in the brief and family therapy field and the various questions and assumptions of this approach are well known. What is less documented is how to draw together the various techniques into a framework for use in the therapy session. This article builds on the preceding papers (Turnell & Hopwood, 1994a and 1994b) — which offered an outline for using the solution-focused model — by providing practical suggestions for applying solution-focused principles in cases that appear not to be proceeding smoothly, and considers how to terminate solution-focused therapy cases.

Establishing what the client wants is the defining motif of Solution-Focused Brief Therapy for us (see Turnell and Hopwood 1994a & b). When we find ourselves stuck with a case or when we consider the timing of case closure, the reference point of what the client wants is, in our opinion, essential to the successful completion of therapy.

When the client reports things are the same or worse in the second session, we do not consider that problematic (Turnell and Hopwood, 1994b). If, however, the client has returned for the third session and still describes things to be the same or worse, we consider that we (the therapists) need to do something different. Looking in part at brief therapy practice, Holsgrove (1989) found that where clients returned for the fourth session, 95% reported improvement in family relationships. This suggests to us that clients are unlikely to return for a fourth session if they are not experiencing change. Further, this corresponds to our clinical experience that if we continue to act in the same manner in the third session and beyond by asking the same sorts of questions, we are unlikely to be helpful and the client will probably not return. In this article we will address some of the things we do differently when our clients are reporting no improvement.

Sometimes therapists get stuck even after progress has been demonstrated. At these times the therapist can often wonder, "How

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† This paper is the third in a series of three articles which offer a framework for solution-focused brief therapy.

will I ever finish with these people?" Therefore, we will also address what to do when there's been progress but it's not enough for clients, or perhaps the therapist, to feel comfortable in terminating therapy.

The case of the young man who just wants to be recognized for what he does

A young man was brought to therapy by his mother following suspension from high school for fighting. He had been in similar trouble previously and had not been doing well academically. His mother also had complaints about his lack of respect for her. The first session was conducted in typical fashion (Turnell and Hopwood, 1994a). After allowing the mother and her son to describe their view of the problem, each responded to the miracle question with answers indicating that the young man would be doing better in school and minding his mother at home. However, the therapist[1] had a sense that the young man was just giving answers that he thought his mother wanted to hear. Since neither the mother nor the young man showed a willingness to work to solve the problems (she thought it was his problem and he thought the school had the problem), a simple observation task was given. This assumption was confirmed when the mother mentioned on exiting that she would not be accompanying her son to the next session.

At the second session, the young man couldn't think of anything that was better for him. He spent most of the session complaining about how the school wasn't willing to listen to his ideas. In anticipation of the third session being more of the same, his mother was called and told that her presence was important at the third session. Changing the participants is one of the doing something different options that can be employed when there is no progress.

In the third session, neither the young man nor his mother could think of anything that was better. After the standard list of options failed (the best day of the week? the best part of the day?, etc.), the therapist employed another option often used when stuck: "shut up and listen". In the midst of all the complaints, several pieces of information popped out: the young man had not gotten into any trouble at school since the last session, nor any trouble at home. Something was not adding up; they should have been saying things were better. However, since the young man had seen little of his mother due to her work schedule, she discounted the lack of problems at home. The young man discounted the absence of problems at school since he felt that he wasn't doing anything different and thought the school wasn't hassling him because they knew he was in therapy. It became evident to the therapist that he didn't really know what the young man wanted. The following is part of the conversation that led to some new ideas about the client's goals.

Therapist: You're not doing anything different?
Young man: Yeh, I changed the way I act a little but not much.
Therapist: How much is a little?
Young man: All depends on how you see it?
Therapist: What do you think the school is going to say they noticed?
Young man: I don't know what they're going to say. They'll probably tell you that he's not even there or something different. I don't know. That's how unpredictable that school is.
Therapist: So it's like you're not even there: no news is good news?
Young man: They only notice you when you do bad stuff. They don't ever compliment you on your achievements unless you get a

1. Larry Hopwood

4.0 or save the old lady
Therapist: What does that mean?
Young man: Just do a really good deed and everybody notices.
Therapist: So they don't notice the small things.
Young man: Yeh.
Therapist: I think you're right there. What do you think it will take for them to notice.
Young man: If you're a bad kid and shape up, you should get recognition for that. If you're a regular kid, that's just normal for that person. If you get into trouble and start shaping up, you should get recognition.
Therapist: Are you telling me that you're trying to keep things under control and the school's not noticing. Is there a time they do notice?
Young man: No.

At this point, things were much clearer for the therapist. It seemed what this young man wanted was not so much doing better in school but rather recognition for his efforts. The next step was to determine his willingness to work toward his goal.

Therapist: How can we get this to change?
Young man: Maybe if I had some help.
Therapist: Would you be willing to try something?
Young man: It all depends but then you wouldn't tell me. All right I'll try it.

With the client's goal identified it was not surprising that he was more willing to do something. Since his goal was for the teachers to notice, the therapist and he agreed that each school day he would flip a coin. If heads came up he would act as he normally did, while tails would see him work extra hard in school that day. More importantly, the therapist agreed to contact the school and have the teachers notice anything that was better. Interestingly, during the first week the teachers failed to notice anything better, excepting one teacher who thought the young man was quieter one morning. The young man missed his next appointment. He was called and told that one teacher noticed something different. Both the young man and his teachers agreed to try it again. The next week almost every teacher reported the young man doing better.

The idea of "doing something different" is an old one in the brief therapy tradition (for example see Weakland et al, 1974 and Fisch et al, 1983). The actual decision and willingness to try something different applies to the therapist as well as the client. What we have outlined in the two previous articles works the majority of the time (as measured by client's scaling progress), but if what we are doing is not working, it seems important to try something different.

We often think of the things we can do differently in terms of who, what, when and where. Who is involved in therapy is obviously central to how it proceeds, so if we are stuck it may mean inviting in another person: maybe the father, the grandmother or perhaps a professional involved with the case. Or, it may mean dividing the family and seeing the parent and child or the couple individually. We might also involve another therapist either in the room or behind the mirror or invite that person to review a videotape of an earlier session.

When clients are seen can be an important consideration. People with some types of problems are better seen in the morning; others in the afternoon. Children who act out over the weekend might be seen on Wednesdays rather than Mondays. We are not trying to trick them into thinking that things are better but rather creating a chance to focus on some small change: the improvement from Monday

to Wednesday as a start. In general, we will see clients weekly until changes are noticed; however, sometimes it is better to make a longer gap between sessions to create a greater sense of leaving the client to their own devices. Often, it is also important to see clients fairly shortly after changes commence, since in talking about these changes with the client they become more meaningful and are more likely to be repeatable.

It is sometimes important for the therapist to be flexible with where therapy takes place. This may be as simple as changing the room where clients are seen. For example, a room with less stimulation might be beneficial for an active child or a room with more for a depressed person. Even changing where people (including the therapist) sit within a room can be a catalyst (and metaphor) for further change. The authors both have considerable experience of doing therapy on the "home turf" of the client whether this be visiting the home, a homeless shelter, a neighbourhood house or local cafe or meeting the person on the streets. This is often of considerable benefit to bringing about change (for example see Berg and Hopwood, 1992).

Changing the what can be the realisation that solution focused therapy isn't the answer for everything or everybody. Maybe another approach such as strategic therapy or art therapy or any number of other possibilities is more appropriate. Perhaps medication or residential treatment should be considered. Often the best approach is to listen to the client, in an attempt to understand what the client really wants and to understand how and what the client really wants to talk about. Although we usually commence second and subsequent sessions looking for improvement it is important to also realise that the therapist is not trying to convince the client that things are better. (The focus on improvement simply reflects the purpose of therapy as we see it.) This realisation allows the therapist to agree with the client and acknowledge the gravity of their situation and to be flexible enough to think of doing something different.

Ideas for cases that seem to drag on forever

John Weakland (1989) has suggested that "life is one damn thing after the other, a problem (on the other hand) "is the same damn thing, over and over". The therapist[2] in the case we will consider below had the feeling that the therapy was bogged down in life's "one damn thing after the other". He had lost track of what the clients wanted, what the problem was, as well as what any solutions might be. In discussions with the other team members[3] it was decided that the therapist needed to do something different. This case provides fertile ground in considering both how to close a case and also what to do when the therapist feels stuck.

The case concerns a married couple, Mary and Paulus. Paulus began to have panic attacks nines years previously. During the nine year period Paulus had given up regular employment, and had sought treatment from numerous health professionals. This treatment gave Mary and Paulus a name and diagnosis for the problem. The sense that Paulus was suffering from "a real problem" namely agoraphobia helped the couple to cope. However, Paulus's problems associated with the panic attacks got increasingly worse. By the time he had come to therapy Paulus would not go out of the house unless he was in the company of Mary or one of his children.

Although the therapist felt there had been some progress over the period of therapy (eleven sessions over the course of six

2. Andrew Turnell.

3. The team comprised Michelle Wilson, Steve Edwards, Helen Turbott and Larry Hopwood.

months), he increasingly found himself feeling bogged down in discussions of day to day problems in their lives, things such as the cleaning of the house, the care of the children, the tidying the yard and so on. In other words, the therapist experienced the therapy as stuck. Larry Hopwood, who had observed the previous session, made the suggestion that something different be done right from the onset of the next session and proposed that the therapy begin in this way:

Therapist: I was thinking about where we were up to and I thought we might start with a question to get an overall sense of things. Um, using a scaling question, if zero is when we started out together.

Paulus: The first time we saw you, you mean.

Therapist: Yeah, yeah and,

Paulus: To now?

Therapist: And ten is when you feel like we don't need to get together again.

Paulus: Uh huh.

Therapist: Where would you say you are now?

Paulus: Um, I think a pretty good, good eight, seven or eight or something sounds right.

Therapist: Really?

Paulus: I was saying to Mary that ah I suppose with Christmas and stuff coming up we probably wouldn't get together much more but maybe if we could sort of you know sort of know that we could come back early next year or something if we had to. It might be a good thing you know just to sort of, have it on standby. That is what I think anyway. I feel that you know that I definitely got something out of it.

Therapist: What is it now that is giving you the confidence that it is time to call it quits at least for the moment?

Paulus: Well I think we have sort of been able to figure a few things out, you know. I think sort of Mary knows where she is at more now than before. We're obviously not all through it you know having got the things we've got, but it surely helped. And for you *(looking at Mary)*?

Therapist: Where would you...?

Mary: Mm, Yeah I, probably about seven um,

Paulus: Yeah seven or eight that sort of thing.

Mary: You know there are some things haven't changed and who knows maybe they never will. Um, but I don't know that you can do that much more for us in our current situation. Um, and some of that I suppose is just whether we want to make a decision to change in some ways or whether we don't and maybe it's not really possible for some of that to be changed to a great extent and maybe it is just a question of acceptance. So, um in some ways we haven't moved that much further along but in other ways we have probably learnt how to, I suppose come to accept a few things that little bit more readily. But there will always be those frustrations and always be those months where it will blow up and I'll probably always think 'oh gosh you know things shouldn't be like this I wish they weren't like this' but I guess they are and I guess it is the same for Paulus too.

Therapist: What would you need to see that would tell you um, because you said it was either like deciding to

change things or just accept things more, at what point would you decide this?

Mary: Well, probably the hardest decision for me is probably one of the hardest decisions of my life apart from marrying Paulus is really probably to sell the house ...

With his last question the therapist has taken the conversation back into more of the same that wasn't working. The therapist has directed the dialogue back into the particularities and problems of Mary and Paulus's day to day life. The therapist certainly has no idea if the clients want his assistance in this matter and has been unable to successfully amplify the improvements with the clients. Interestingly, at this point of the therapy it seems the improvement was more meaningful for the client than the therapist. Following this question the therapist talked to this couple for more than 15 minutes, principally about the issue of whether to sell the house. During this time, as with the previous few sessions, he experienced the discussion as becoming increasingly bogged down. Finally, the team could stand it no more and rang in suggesting the therapist return to the original question. The therapist was ready to refocus on building the improvement dialogue and followed the suggestion:

Therapist: Can I bring you back to that original question that I asked. In terms of you saying since we've been getting together it has gone from a zero to a seven. What other things make you say that you've got to that point now?

Paulus: Actually, probably the way Mary said it was better. We sort of you know we see something now, like before we you know we would chuck a fit over it. I mean it's there, what can you do about it? You know you can't do much about it, so you just got to, just about accept it and walk around it the best way you can you know. Yeah I think that, that's the way.

Therapist: And how have you seen yourself accepting and working around things?

Paulus: I think, now if something is, you know something comes up before where I would sort of you know throw a fit and take it out on Mary, [now] I probably think well half of this is my fault you know. It's because the way things are so you know I really try to sort of settle down. Maybe not as much as I should but it is obviously less ...

Therapist: So what's made the difference for you to be able to have that sense of acceptance and be able to work 'round things?

Paulus: Well I think Mary's sort of um maybe been able to see how involved this phobia thing is you know, ... so it doesn't hype me up about her not seeing how bad it is or whatever. You know I mean she understands more about it now so it makes things less what's the word, frustrating for me you know. It's just all those little things you know.

Therapist: Because she understands you?

Paulus: Yeah yeah, I think that's what it is you know. In the last year she's sort of understood a lot more and maybe not living with it had to accept the way things are a bit more.

Mary: I think some of that hasn't always been so much that I understand so much more but the fact that I, that he knows that I understand it more. Whereas before you

know I sort of probably mentioned in the past I didn't want to bring too much attention to it hoping that he might be sort of side tracked sufficiently to think he'd get through. Obviously that wasn't working ...

Therapist: Have there been other differences that bring it up to a seven for you? ...

Mary: Um, I think I have just stopped expecting that things are going to change as far as the agoraphobia at least for the time being ... I guess I have just sort of accepted that it's him having this and he's at home. The other thing is that so many more people in the family and friends are now aware of it and now most of them know what agoraphobia is or you know at least it rings a bell in their head when I am speaking of Paulus.

Therapist: And that makes a difference?

Mary: Yeah because most of them for ages you know you sort of sat down and started explaining what was going on and you know two months after they would sort of say 'Oh, Paulus still hasn't got a job' and the rest of it had gone over their heads completely and they had forgotten or I guess I hadn't explained in detail whatever. So people being more aware, that's family and friends actually realising that there is a problem there.

Therapist: How would you say you created that understanding?

Mary: I suppose just by talking about it and being open with everybody ...

Therapist: Has that made a difference for you Paulus?

Paulus: Yeah, same sort of line you know. People sort of know about it more. So I don't sort of feel as bad you know. Not that I did before anyway. I mean if I'm sick, I don't really give a shit about what people think mate...you know. I mean, they're not the one with the stuff. But I think it makes it easier for, for you know... *(Mary comes in).*

Mary: I think it makes it easier once there's a name to it, people realise once something's got a name "Oh!", you know, if you just vaguely just start talking about the problem then it doesn't really mean anything, but with a name, people tend to,

Therapist: Was there anything else that has brought you up to that seven-eight Paulus?

Paulus: No, no I think in general that's what I want to see, Mary sort of learnt a lot more about it and knows where we're at. Sort of tries her best to cope with things the way they are and ... *(Mary comes in).*

Mary: And I think, what about Doctor Jones? I would have said the Doctor that has sort of, we've been more familiar with recently. He accepts it fairly readily that Paulus's got a problem and he sort of has said "Look, if you've had it for this long, you're virtually likely to have it for the rest of your life and don't go placing too many more expectations on yourself and that way you just sort of make it over it." And it's sort of nice to hear a professional person say that instead of trying to keep passing it off and "Oh yes, you'll get over it, you'll get over it, you'll get over

it." Um, because that's made it hard for me too, because I hear a professional person saying that and, *(Paulus comes in).*

Paulus: I think Mary needed to hear that more than me actually you know.

Mary: Yeah, yeah, maybe I did.

Paulus: Because she's already been told that you know, I'll get over this. So she expected it from me and you know, I know damn well that you know, I might but it's very very unlikely. It's very hard to get over. So I knew sort of roughly where I was but Mary was always expecting me to get over it. But she'd been told that you know, she'd just about been programmed that I'd get over this thing. This new doctor, he said, You know, you've had this shit for nine years"; he said "You're gonna go grey with it, mate." You know? I said, "Yeah, but hopefully not". He said, "well you can always hope about first division *(a form of lottery)* too" ...

Therapist: *(To Mary)* So what have you noticed different about Paulus as his acceptance has become more part of *(Mary comes in).*

Mary: He's nowhere near as aggressive as he used to be, nowhere near.

Therapist: What happens instead?

Mary: Well sometimes I can see his dislike for a situation, he'll pull a face you know or he might make some little sarcastic comment, but that tends to be it more now.

Therapist: You say things are a seven, a seven, eight. I guess the other question is, what what ahh, needs to happen so you can keep this going?

Mary: I suppose I just have to accept that he's, his agoraphobia and the situation there and, um, I don't know. Just accept that and to try not to get too frustrated with um, wishing things were different um, which on the whole, I think I've been fairly good about.

Therapist: Where's your confidence from zero to ten that you can keep this going?

Mary: Ah, six. Though I must admit there are moments where I think "Oh gosh, I don't know if I can carry on living like this." But ...

Therapist: So what would need to happen for you could have a little more confidence?

Mary: I don't know. I suppose if he leaves me just to those few little things that I know I have to do, to stay sane, to stay in control of what I know I can control as best I can *(Mary is talking here of taking control of the budgeting discussed earlier in the session)* ...

Therapist: What about you Paulus, what do think needs to happen so you can keep this going?

Paulus: I think, just the way it's been going I suppose, you know. Mary's sort of understanding it and being able to accept it, and whatever. Just in general, that, you know ...

Therapist: So with all of this and with the situation that you're in, where's your confidence that you can keep this going?

Paulus: At times good, at times bad, you know.

This transcript shows that the therapist's own thinking can create a sense of stuckness in a case. As well as feeling bogged down by the discussion of the day to day particularities of

the clients' lives, the therapist had also become stuck with the idea that "I have to do something about this agoraphobia". This thinking on the part of the therapist undermined a central tenant of Solution-Focused Brief Therapy that "the client's goals and solutions were more important than the problems the client depicted" (de Shazer 1991 p57).

This case also demonstrates a useful distinction between overall progress in the client's life and progress during the course of therapy. In the first few sessions we ask scaling questions relating to overall progress since these allow us to focus on any small progress clients have made before they commenced therapy. That is, their situation at the time of the first session is not usually the worst it has ever been. The client's rating of overall progress often increases rapidly during the first few sessions but then the rate of increase slows. So, when clients start therapy with an overall progress scaling of (say) 4 and advance to 6, there is not much room to measure change between those two numbers. The small numerical difference may not assist us in making the changes as meaningful as they could otherwise be. For this reason we often find it useful to change the nature of the progress scaling to reflect progress during therapy since it is more sensitive to change. It not only more clearly delineates progress during therapy it also implies an end point for therapy's usefulness.

The transcript presented above presents a moving story of a couple finding their own solutions to a difficult and prolonged problem. Although the therapist had assisted the clients in discovering their own unique solutions, by this final session of therapy the therapist needed to 'catch up' with what the clients had achieved. The "progress during therapy scale" allowed the therapist to realise the extent and significance of the changes the clients had made.

Bringing cases to a close

Walter and Peller (1992 p40), suggest that the brief therapist should approach each session as if it were the last. Solution-Focused Brief Therapy has also always operated on the maxim that therapy finishes when the client, by their own criteria, reports sufficient improvement. This presumes that the possibility of termination is in the therapist's mind and would also suggest the subject should frequently be under discussion in the therapy. In the case just considered, the therapist had lost sight of the possibility of the next session as the last. Fortunately the team had not, therefore suggesting the use of the "progress during therapy scale", that postulates "10" as termination of therapy. As Paulus indicated at the beginning of the session, he and Mary had also not forgotten about the possibility of termination and as long as the option of return was available, they were ready to call at least a temporary close to therapy. This session was all about the clients and therapist amplifying the improvement to demonstrate to each other that termination was appropriate.

We would recommend therefore that when the therapy seems to be bogged down it is important to reconsider what the clients want and how far the clients have progressed toward their goals during therapy. While the "progress during therapy scale" is one question that does this, there are many other ways of achieving the same end. It is certainly our view that it is important for the therapist to keep track of progress in each session. Most commonly we do this using scaling questions. In response to a scaling question there is no magic number that indicates the client's readiness to terminate. Some clients are ready to terminate at a 4 (we are sometimes surprised how little is enough for a client to say they've achieved what they want. For a case example of this see Hopwood and de Shazer, 1994); others at a 9. But there are some factors that seem to be important. Usually most clients

need to see a differential of at least two numbers and clients who have achieved at least a 6 on the progress scale report greater satisfaction on a 6 month follow up (De Jong and Hopwood, unpublished).

To call an end to therapy, clients not only need to experience progress but usually also need to have confidence that they can continue the progress. Hence we begin to scale confidence once progress is reported (see Turnell and Hopwood 1994b for further consideration of this). Generally, the confidence scaling lags behind the progress rating and clients need to experience progress over a period of time before they become more confident. This is well demonstrated in the case we have just considered. Paulus reported that his confidence was, "at times good, at times bad, you know" and Mary says of her confidence: "Ah, six. Though I must admit there are moments where I think, "Oh gosh, I don't know if I can carry on living like this." In our experience, client confidence also increases when therapists give clients increasing periods of time between sessions to solve their own problems and continue the changes they have made. When he hadn't heard from them, the therapist phoned Mary and Paulus approximately three months after the last session. He found that the changes they had described had held up and, more than that, Mary and Paulus had also become increasingly confident that they could get on with their own lives without the need for further therapy.

We have tried to emphasise that the defining principle for how we do therapy is what the client wants. Paradoxically, it is only when clients say they don't need to see us again that we really get a sense of what they wanted. The progress that is demonstrated at termination, often is not the same as the progress that clients say they want at the beginning of therapy. The progress during the course of therapy gives them and us new insight into what really makes a difference in their lives.

Final discussion

These three articles (this paper and Turnell and Hopwood 1994a & b), present one particular structure for doing Solution-Focused Brief Therapy. Drawing on a usual or preferred structure or map provides the therapist with an organising principle for the discussions they have with their clients. While this is invaluable (at least for most of us), problems can arise when the therapist becomes a slave to the structure or, the structure becomes treated as a set recipe. If the structure becomes dominant over the client's perspective and goals, the therapy is unlikely to be helpful for the client. Nylund and Corsiglia (1994) propose a useful way of thinking about this, suggesting that when we become a slave to our structure the solution-focused approach can actually become "solution-forced". Previously, our own way of expressing this sentiment (perhaps more crudely) was that when the structure becomes pre-eminent, the therapist will find themselves "getting in the client's face" with the solution focused techniques and questions.

The first case example in our first paper (Turnell and Hopwood 1994a), is an example of the therapist beginning to force (or get in the face of) the client with the supposed exceptions. Although at this point the therapist may have been following a structure of Solution Focused Brief Therapy, he was no longer following one of the pre-eminent principles of the model, that of cooperating with the client's perspective. (See de Shazer 1985, 1988 & 1991 for consideration of developing a cooperative relationship with the client).

We have repeatedly stated that the organising principle of our work is to focus on what the client wants. We assume that, as a minimum, all our clients want to have the sense that we have understood and heard them when they talk to us. Nothing over-rides the need the client has to feel understood and heard. Where

the solution-focused approach is used well, it will enhance this sense for the client and therefore foster cooperation between therapist and client.

Finally, what we have articulated is not the structure for doing Solution-Focused Brief Therapy as there is no one structure of this model. There are many. In fact at best, the solution-focused model and structure is freshly re-created, every time the solution-focused therapist sits down with a client (and, if we are lucky, also every time one of us writes a paper or teaches a workshop on the subject).

A word of thanks

Our hope in writing these three articles has been to clarify our thinking for our colleagues and to further respond to the many questions from those who have been involved in our training and consulting work. For any success we have had in this endeavour, we in large part owe our thanks to the challenges of those individuals. For the shortcomings we will have to turn to them for more questions to stimulate and clarify our thinking. We have tried to make these articles reflect our most current thinking. That turned out to be difficult because as we continued to practice in different locations, we found ourselves already starting to think and practice differently. As we have just indicated, there is no such thing as the solution-focused model. We hope you come up with one that works best for you.

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