BEGINNINGS

How we begin an interview matters. How we begin an interview not only sets the tone for the interview but also communicates to the client much about what we believe is important. For example, if I begin by asking the client "What's the problem you've come here about?", I am communicating that the problem is something I consider important, since I am giving it primacy in our conversation.

Most therapists begin their interviews with some general statements or questions. These might be comments about the weather, a general enquiry about traffic or transport getting here, or enquiries about work or school and will generally include some statement of welcome.

In the few years before his death, Steve de Shazer routinely began his sessions in a particular manner. While not an essential part of the Solution-Focused approach, I find this particular opening extremely helpful and other authors have echoed this sentiment (for example, Korman, 2004).

> *Thank you for coming; I hope this (coming here, talking to me) will turn out to be helpful for you; of course, there's no guarantee about that. What I can guarantee is that I will do my best; and I assume you will too, and together we'll see where we get to. (de Shazer, 2003; Korman, 2004)*

When we enter the room with a client, we have in our minds some ideas about how the conversation will proceed, including the kinds of things we will say and the kinds of questions we will ask. However, you can only

really PLAN your first question or comment. Once the conversation is under way, you cannot be confident exactly where it will go or how it will proceed, so it is difficult to plan exactly what you will say. However, you can be reasonably confident in planning your opening lines.

If our opening lines are all we can really prepare, we may as well make sure they are good ones! Therapy is a purposeful activity and the therapist's job is to make it purposeful. How we begin the interview matters; and therapists are encouraged to give serious thought to how YOU begin your conversations with clients.

de Shazer opened his sessions with various versions of the opening shown above. At first glance, it may not appear to be anything special; yet, it is actually a carefully crafted therapeutic opening.

Let's examine his words more closely.

Thank you for coming ...

This is a seemingly innocuous beginning, yet potentially a powerful one.

Think about the last time you went to see your doctor. Did he or she say, "Thank you for coming"? Probably not. In fact, it is more likely that you said (or, at least, thought), "Thank you, doctor, for seeing me" (even if you really didn't want to be there!).

For this professional, who is being paid to see us, to begin by thanking us for coming, is profoundly respectful.

I hope that talking to me will be helpful for you ...

Right at the beginning, we are signalling some hope or expectation that this meeting or conversation will be helpful or useful. The therapist is entering this encounter with the aim that it will be useful for the client.

Note that we did not begin by saying, "I hope it will be pleasant for you", nor by saying, "I hope it will be fun". We did not begin by saying, "I hope it will be bearable", "I hope it will be quick" nor "I hope it will be interesting". We begin by signalling clearly that our hope (expectation or aim) as therapist is that this will be helpful or useful. That is the basis on which the session should be judged. We may also hope it will be pleasant, or interesting, or quick; however, these are not the criteria against which we would judge the success of the session. Our aim, a purposeful one, is about this session being useful — that is, making a difference.

Of course, there's no guarantee about that ...

However, we are also realistic. Our aim is that it will be helpful; however, we cannot guarantee that.

If the client has come thinking that the therapist will have all the answers; well, there's no guarantees about that! If the client has been told by their mother/partner/teacher that this therapist will be able to tell you what you should do; well, there are no guarantees about that!

What I can guarantee is that I will do my best ...

The therapist is making a commitment to the client. I will do my best to make sure this session is helpful for you.

and I assume you will too ...

I assume you will do your best, too. The therapist is being quite affirming of the client's ability and cooperativeness. However, at the same time, the subtext is a message that you (the client) are expected to contribute to the work that will happen here.

and together we'll see where we get to.

This is a collaborative enterprise for therapist and client together.

As suggested above, how we begin matters. These opening words from de Shazer do not constitute a magic formula; however, they offer a way of beginning that communicates from the start that this is to be a respectful and collaborative process that has the aim of being helpful.

After walking through the door

So, you might ask, do we launch into the opening words suggested above as soon as we walk through the door? Where does "small talk" fit? Or what about "building rapport"?

In an interview with a young woman with a history of depression and suicide attempts, and who I knew was not coming to see me voluntarily, (Durrant, 2010), I introduce myself and jump straight into these opening lines.

Therapist: Hi, I'm Michael.

Sam: I'm Sam.

Therapist: Thank you for coming tonight. I understand that your mother made the appointment for you … that she wanted you to come … and that you didn't necessarily agree with her.

Sam: No … that's right … I've only come 'cos she was on at me to see someone … I told her that no-one has been able to help … but I figured maybe if I came along it might shut her up a bit.

Therapist: Okay … so your Mum was keen you should come … you weren't so sure … well, I appreciate you making the effort to come, then. … Yes … I want to thank you for coming. I hope it will turn out to be helpful for you. Of course, there's no guarantees about that. What I can guarantee you is that I will do my best … and I'm sure you will too … and together we'll see where we end up.

I knew that Sam did not really want to be talking to me. It might be tempting, in such a situation, to try to put Sam at ease by asking her questions about work or social activities; however, it seemed to me that someone who does not want to be there may actually be frustrated by questions that seem irrelevant. With Sam, I acknowledged her wariness about being here and then moved immediately to my usual opening, in an effort to begin to construct a particular context for our meeting.

With some clients, a slightly longer "social" phase may be appropriate. In his interview with a 16-year-old young woman, (de Shazer, 1998) asks her about school.

Therapist: I'm Steve.

Client: I'm Naomi.

Therapist: That's a nice name.

Client: Thank you.

Therapist: So, what school do you go to?

Client: West High.

Therapist: Do you really go, or are you just supposed to go?

Client: *[laughing]* Oh, supposed to go.

Therapist: Okay. So, how often do you get there?

Client: Maybe one or two times out of a week.

Therapist: And, when you go, do you stay the whole day?

Client: Sometimes.

Therapist: How come?

Client: I've got other things to do!

Therapist: No … how come you do go sometimes? How come, when you do go, sometimes you stay the whole day?

At first, this seems little more than an interested conversation about what school the client attends. Such might be seen as typical of a "rapport-building" conversation with a client. However, in Solution-Focused Brief Therapy, building rapport is not in itself an aim. If we decide to devote time trying to build some kind of connection with the client, it is a purposeful activity that is not primarily designed to make the client feel at ease or to build rapport. Our aim is to communicate from the beginning that we view the client as someone with strengths and abilities. We sense that Naomi experiences de Shazer as interested. After establishing, apparently without judgement, that her school attendance is less than optimal, she may be surprised that he does not join the other adults in her life by lecturing her about this but enquires, "How come?". Naomi assumes that he is asking, "How come you don't go to school?" and begins to answer. However, he interrupts and clarifies, "No … how come you do go sometimes? How come, when you do go, sometimes you stay the whole day?".

This is presumably not what Naomi was expecting. However, his apparent "general" questions are quite specifically aimed at uncovering success or competence and inviting her to reflect on this.

He goes on to ask about what she does well at school and also asks, "And, if I was to ask the teachers, what would they tell me you are good at, that you wouldn't bother to tell me?". Many are used to asking adolescents what they are good at at school, only to be answered with a shrug, or a dismissive, "nothing!". This question is difficult for adolescents to escape from! It is a question that can be useful in other contexts too, as part of our search for competence.

> *"If I was to ask your wife/husband, what would she/he tell me you are good at, that you wouldn't bother to tell me?".*

"And, if I was to ask your work colleagues, what would they tell me you are good at, that you wouldn't bother to tell me?".

Problem-free talk

A number of writers have suggested that an introductory period of "problem-free talk" is an essential part of the therapy conversation. This has been described as "rapport building", the "social phase", the "getting to know you phase", and so on. Sharry (2004) suggests that problem-free talk is an important part of building the therapeutic alliance and Lowe (2004) sees it as something that happens before the "getting down to business" phase and which helps clients feel welcomed and included.

In my early family therapy training, the importance of "joining" was stressed. Minuchin (1974) described "joining" as the therapist connecting with the clients and he described a parallel process whereby anthropologists "join" the culture they are studying, in order to be accepted and for the members of the culture to feel comfortable with their presence. If the members of the culture feel comfortable with the presence of the anthropologist, then they are more likely to relax and behave the way they would if this outsider was not there. Thus, "joining" is about helping the family feel at ease in the presence of this "stranger", so they will then behave "normally". The idea of the importance of "joining" with our clients, before beginning the actual therapeutic discussion, has largely been assumed ever since.

It is worth noting that Minuchin uses the example of the members of the culture needing to feel accepted and at ease, so that they will then behave more or less normally, despite the presence of the anthropologist — so that the anthropologist might then observe their "normal" activities. In Minuchin's Structural Family Therapy, the therapist's aim is to observe the family members interacting in more or less their normal manner, so that the therapist may have accurate information with which to make a family assessment. Thus, the therapist needs to put the family members at ease, to join with them, so that they will feel at ease.

However, in a Solution-Focused approach, we are NOT aiming to see clients interacting "normally", so that we can assess their interaction.

Moreover, I suggest that therapy is not — and can never be — a "normal" activity. I think we therapists do well to remember that therapy might be a natural activity for therapists; counselling might be a natural activity for counsellors; however, it is definitely an UNnatural activity for clients. Getting on with their lives is what clients do. Talking about, and reflecting on, how they get on with their lives is NOT what they do naturally. I think that it is important that we remember that clients are entering OUR space, our world. Hopefully, we feel comfortable in this world; however, we should not assume that they will feel comfortable, no matter what we do to try to put them at ease.

It is important that we help clients feel as much at ease as possible. However, we should not pretend that we can help them feel completely at ease; and, perhaps, we should not try to. Therapy is *work* — for therapists, but also for clients. It is important that clients feel comfortable; however, perhaps we sometimes do a disservice by trying too hard to help them feel comfortable.

My colleagues at BRIEF in London have suggested that the importance "problem-free talk" is perhaps an idea we should question (George, Iveson, & Ratner, 2001). They suggest that the therapist should only be guided by how the client wants things to be. Our aim is to help clients achieve what they want to achieve. Thus, George and his colleagues suggest, our questions should be directed towards what the client wants to achieve. Questions about school, or work, or holidays, or how you got here today MIGHT be pleasant and interesting; however, they are NOT necessarily questions that relate to why we are here … to how you (the client) want things to be different.

Harry Korman has noted that a brief exploration of the client's activities can be helpful in ensuring that our focus is on the client's life.

During his last years, Steve [de Shazer]'s first question was very often: "How do you spend your time, what do you do with yourself all day?" He would listen to the answer for a couple of minutes and would then ask "How will [you] notice if having been here was useful?" and then he would move on from there. He said he used the first question (how do you spend your time, what do you do with

yourself all day) to get out of the therapy room and into the client's life as quickly as possible.[1]

My own practice has evolved and I notice that an initial period of "problem-free talk" is less frequently part of what I do. That is not to say that I never ask clients about their schools or work, or that I don't comment about the weather or ask if they had any difficulty finding my office or managed to find a parking space. However, I no longer think about a "social phase" or a "before getting down to work phase". Engaging clients is crucial; however, we should consider what it is we are engaging them in. My aim is to engage clients to join me in a conversation that will help them move towards where they want to go. Engagement is not somehow separate from the therapeutic process and thinking about it as a separate "phase" or part of therapy may lead to an unhelpful emphasis on "social" chit chat. We may well ask about work or school or other aspects of their life — and, when we do have such conversations, we should consider this not simply as putting the client at ease but as part of a gentle exploration of strength and competence — however, more and more I think that the best way to engage clients in a particular process is to get on with that process.

How will you know that coming here has been useful?

Following any initial conversation and my now-standard "Thank you for coming …" opening, I will always move quickly to questions that help construct a context or expectation of change.

How will you know, at the end of our session today, that coming here was useful for you?

"Suppose, your meeting with me today is helpful. What will be the first sign to you that things are different?" (Simon & Berg, 1997)

"What needs to be different today or tomorrow — something small — as a result of you talking with me, for you to think or feel that it was a little bit helpful having talked with me today?" (Korman, 2004)

Our job is to help people change. Paradoxically, most people come along feeling stuck and, when you feel stuck, it is hard to think about change. As I have said above, the way we begin sets the context for the conversation. Our challenge is to begin in a way that communicates, "The purpose (or desired outcome) of this conversation is that something will CHANGE".

Traditionally, therapists began by asking some version of "What's the problem?". This seems natural, since most people know that people come to therapy because they have a problem (either in their view or in someone else's view) and clients will frequently come to therapy expecting that the first thing they will be asked is to provide details of the problem. By asking this question, the therapist communicates that understanding the problem is what he or she wants to do — is what is important. Some Solution-Focused therapists, realising this, abandoned asking, "What's the problem?" and replaced it with a seemingly more neutral or innocuous question such as, "What brings you here today?". Indeed, there are examples of Steve de Shazer and Insoo Kim Berg beginning with this question, and for many years it was my practice as well. However, "What brings you here today?" is *really* asking, "What [problem] brings you here today?". It is still a version of "Why are you here?", which most people seem to hear as a question about the problem.

De Jong and Berg (2008) describe how they begin by asking, "How can we be useful to you?", and they comment that clients generally respond by taking about a (or the) problem. Once clients have begun to talk about the problem, it seems only polite to ask a little about it. De Jong and Berg comment that they then think about ways to turn the conversation away from problems and towards solutions. That is, their initial question seems to start therapy heading in the direction that therapists do not want to go!

Solution-Focused Brief Therapy is not driven by what the problem is. For the Solution-Focused practitioner, it is most important to understand how the client wants things (in their life) to be different or better, which is fundamentally different from understanding what they (or someone else) thinks is the problem. Thus, the question, "How will you know that this

1. Comment made on the SFT-L Solution Focused Therapy internet discussion list, June 2008.

session has been helpful?" is a question not about the problem that may have precipitated the therapeutic encounter but about the hoped-for change that may result from it.

> *Stories initiated in Solution-Focused brief therapist-client interactions are progressively oriented. Progressive stories emphasize how clients are moving toward desired goals; thus they are designed to justify hope and optimism. The progressive stories constructed in Solution-Focused brief therapy may be contrasted with the "stability" and "regressive" stories that clients bring to their initial meetings with ... therapists. The latter stories emphasize how clients' lives are not changing ... or are getting worse. (Miller, 1997, p. 61)*

With a client who is overwhelmed with pessimism and clearly does not believe that therapy could possibly be useful, de Shazer (2003) asks, "How will your mother ... or your best friend ... know that you coming here to see me was useful for you?". Note that this is really another way of asking, "How will your mother know that you are a little bit better?". After exploring what signs the client's mother would see that would tell her that his coming to therapy had been helpful (that is, that he was in some way "better"), and what signs the client's best friend would see that would similarly signal that progress was being made, he comes back to, "And how about you? How will you know that coming here has been useful for you?".

Thus, these questions are inviting clients to begin to imagine things in their life being DIFFERENT. If we can imagine it — particularly if we can describe it — then, perhaps it is actually achievable!

Further, if I have begun the session by saying, "Thank you for coming; I hope that this will be helpful for you ...", it is perfectly logical that I should then ask how you will know that my hope has been fulfilled.

The common project

The Solution-Focused Brief approach is not static. Whilst it's fundamental focus and assumptions have not changed, emphases and nuances continue to evolve over time. I believe that the recognition of the importance of "How will you know that this has been useful?" is perhaps the most important development in the last few years.

This focus has been implicit in the Solution-Focused Brief approach for some time. Very early in the development of the approach, Eve Lipchik wrote about asking clients, "How will you know when you don't need to come here any more?" (Lipchik, 1988) This was a radical departure from beginning with, "What's the problem?" and clearly oriented the therapy conversation, from the outset, to future change. Lipchik observes, "The answer to this question will contain a solution." (p. 107). Consider this question. It includes three embedded messages to the client — potentially powerful messages. First, it signals (the therapist's belief) that there WILL be a time when you don't need to come any more. Second, it signals that YOU (the client) will be able to know when this is, without needing the therapist to tell you. Third, it signals that you can know that NOW, rather than having to wait until it happens.

However, this radical shift in orientation does not seem to have been discussed explicitly as the approach has grown. While not writing a great deal about it, the transition is evident in videotapes of Steve de Shazer's work. For example, he begins an early interview by asking, "What brings you here?" (de Shazer, 1995); in another interview, he has moved on and asks a young woman, "So, what needs to happen here for you to know that coming here was worthwhile?" (de Shazer, 1998); and five years later, he asks a client, "How about you? How will you know that coming here has been useful for you?" (de Shazer, 2003).

More recently, Harry Korman from Sweden has taken up the importance of these opening questions and given them the careful examination they deserve (Korman, 2004). Harry has coined the term "the common project", since he says that these kinds of opening questions are about constructing a shared aim, or "project", for client and therapist to have in common. That is, clients and therapists have different jobs; however, they both should focus on what results the client hopes or wants from the session. That is their "common project".

Korman comments:

> *We focus the interview around what the client wants. What is something small — the smallest thing that could be different in the client's life that would make him or her feel that talking with us has been helpful. What could be a different thought, feeling or action —*

> *what could happen today after the session — or the day after — that would make the client say it was a good idea to come and see us and talk about their problem. … These questions are a way to focus the dialogue directly on the client's purpose with the conversation. … It is the client who needs to decide what changes he or she wants and thus what our work together should be about, so we can't start asking other questions before we have an answer to this one. (Korman, 2004, p. 3)*

He underlines the importance of this question by commenting that, if we ask ANY other questions before having the answer to how the client will know, then our questions will inevitably be based on OUR ideas about what the client should want rather than on the client's ideas.

Focus on the client's life — NOT the therapy process

It is important to note that these questions are asking about what will be happening (be different) in the client's life as a result of coming to therapy, not about what should happen in the therapy process. This distinction may not, at first, be obvious; however, I believe it is a crucial distinction.

Some therapists ask a version of, "What do we need to do here for this session to be useful?".

In a case example, Yvonne Dolan asks a young woman, "What would need to happen here so that when you leave you could say it was worth your time, the time you spent … that it was worthwhile for you?". She follows this with, "So, at the end of our time, you're walking out the door. How would we have spent the time so that you'd be able to say, 'Well, I got something from it.'?" (de Shazer & Dolan, 2007, p. 15).

This is a very different question from, "How will you know this session has been helpful?". One question is asking about the **process** of the session, the other is asking about the **results** of the session. This is an important distinction. As a therapist, is my primary concern about the process of what I will do with the client, or is my primary concern the results of that process? Solution-Focused Brief Therapy is always concerned with — indeed, is driven by — the outcome the client wants or hopes for. "What needs to happen here?" (or variations of that question, such as "What would it be most helpful for us to talk about?") are therapy-focused questions, not Solution-Focused questions.

In Solution-Focused Brief Therapy, we are concerned with how the client wants things **in their life** to be. We do NOT want to focus on what needs to happen in therapy to achieve that. Our clients have had lots of experiences of thinking about what needs to happen … and then deciding that that is not possible or achievable.

Korman (2004) comments that, when asked, "What needs to happen here for you to know it was helpful?", clients will typically begin talking about the problem (since talking about the problem is what they naturally expect is what happens when you go to therapy!). In contrast, asking what will happen **as a result of** coming here moves the focus to the client's life outside therapy.

Of course, if a therapist does ask "What needs to happen here?", he or she can follow this up with, "and how will that make a difference (in your life)?", and the focus has now shifted to the client's life. In the example mentioned above, when Yvonne Dolan asks, "What would need to happen here …", she managed to elicit an answer that points to a change in the client's life.

Therapist:	How would we have spent the time so that you'd be able to say, 'Well, I got something from it.'?
Client:	Right now, I think I need help how I should handle a situation.
Therapist:	Mmm-hmm.
Client:	I feel really confused. I don't know what to do.
Therapist:	So you might have an idea about how to handle it? (de Shazer & Dolan, 2007, pp. 15-16)

"You might have an idea about how to handle it" is an outcome description rather than a process description, and Dolan goes on to ask where the client is already towards that outcome.

When clients talk about process anyway

Sometimes, despite how careful we may be in asking a "How will you know …" question, clients still respond with an answer about process.

You will have told me what I need to do to sort this relationship out.

Well, I will have been able to get all this stuff off my chest. Someone will finally have listened.

Well my doctor said I need to talk to someone about all this and not just hold it all inside.

You'll have given me some medication.

You'll have been able to arrange respite care to give us a break.

I will have worked through my feelings about what happened.

These are all answers that reflect what the client imagines will happen in the therapy conversation. They may or may not be realistic hopes; however, they do not include any clue to changes that will begin to happen in the client's life.

A simple question can remedy this.

Okay … and, when that happens, how will that make a difference?

So, when you're at home tonight or tomorrow, after that has happened, how will things (you) be different?

Okay, and how will you know you've worked them through? What will be different that will tell you that?

As with any descriptions of future difference or outcome, we are aiming for detail and then for existing examples of that happening.

Whenever we help clients build a picture of any aspect of their preferred future (how they want things to be different) —

1. We want the description to be as rich and detailed as possible, which will require asking, "How will that make a difference?", "How ELSE will that make a difference?", "And how else?", "What will other people notice?", and so on.
2. We then want to explore when any aspect of this future has already happened.

I JUST WANT MY LIFE BACK

Sarah, 33 years, gave birth in her car at 16 weeks into her pregnancy. The baby girl did not survive. Sarah was referred by her family doctor because she was worried she would not be able to cope on her own once husband returned to work. This session was a week and a half after the birth and just three days after they had buried baby Celia with a teddy bear. Sarah was very distressed and spent much of the session crying and rocking back and forth. The session involved much silence and long pauses between the therapist's questions.

Therapist[2]:	*[Ushers client into counselling room]* Hi, Sarah. As I said to you outside, my name's Frances. Thank you for coming along today. I hope it will be helpful for you. Your doctor told me a little bit about what's happened. I don't know all the details, but it sounds like these last couple of weeks have been pretty terrible.
Sarah:	*[nods — sobbing quietly]*
Therapist:	So, how do you think you will know that coming here today has been helpful for you?
Sarah:	*[flat]* I don't know. *[Begins crying]* I just want my life back. I just want my life back.
Therapist:	*[Passes the box of tissues and waits until she's more settled]* What will that be like, when you have your life back?

2. The therapist was Frances Huber.

Sarah: I can't get my Celia back.

Therapist: No, we can't get baby Celia back.

Sarah: *[More crying and sobbing and rocking]*

Therapist: Would it be okay if I asked you some questions?

Sarah: *[Nods]*

Therapist: How long have you been with your partner?

Sarah: We've been together 7 years, married for 3. We've been trying to get pregnant through IVF for 2 years. This is the closest we've come.

Therapist: How have you been managing since it happened?

Sarah: John has stayed with me the whole time. I think everyone is scared I'll do something.

Therapist: You mean they're scared you'll …

Sarah: Yes … you know … hurt myself or kill myself or something.

Therapist: Would you?

Sarah: No, I could NEVER do that to everyone. *[More crying]*

Therapist: You seem very certain about that.

Sarah: No, everyone's already been through so much, I couldn't do that to them.

Therapist: So, what have you been doing with John?

Sarah: We watch TV. Watch movies.

Therapist: Does that help?

Sarah: Yes. But he has to go back to work next week. I don't know how I'll manage on my own. *[More crying]* I just want my life back.

Therapist: What else have you been doing other than watch TV and movies?

Sarah: I've only left the house for medical appointments. I can't go out by myself. That's why I'm so worried about John going back to work.

Therapist: Hmm. I noticed, when I came out to the waiting room, you were sitting there by yourself.

Sarah: Yes, I came here by myself.

Therapist: Hmm. Really? *[Gently]* How were you able to do that?

Sarah: Oh, John had to get the car fixed or something.

Therapist: Really? I guess I'm wondering how you were able to do that … to come by yourself.

Sarah: I don't know. *[Crying]* I just want my life back. *[More crying and rocking]*

Therapist: *[Waited until Sarah was calmer, then asked very, very gently]* What will that be like, what will be happening when you have your life back?

Sarah: I'd go out to dinner with John … I could go to the shops … *[pause]* I'd be going back to work.

Therapist: What sort of work do you do?

Sarah: I'm a preschool teacher. I've done it for 13 years. I was so bored with it … I was SO looking forward to quitting and being a mum.

Therapist: What else will be happening when you have your life back?

Sarah: I'd go out to dinner with friends. *[Pause]* I'd try to get pregnant again. *[more crying and rocking]*

Therapist: Hmm. How will you know you are going to be able to manage on Tuesday when John has to go back to work?

Sarah: *[Pause … thinks]* I could ask Mum if I can go to her place … or ask her to come to my place.

Therapist: Okay. So arranging that would tell you you'll be able to manage. What else?

Sarah: I could walk Rufus. He's our dog.

Therapist: Hmm. So asking your Mum to come over or if you can go over there; walking the dog.

Sarah: Yes. You know. Having some plans … some routine.

Therapist: And John's going back to work on Tuesday? I could see you again on Tuesday or Wednesday, if you think that would be helpful … but these things will tell you that you'll be okay until then?

Sarah: Yes.

In this example, the difference between two possible opening questions is clear. Had the therapist asked, "What needs to happen here for you to know that coming here was useful for you?", the client would have been

invited to think about the process of what might happen in this room over the next fifty minutes or so. She might have said (or thought) something along the lines of, "Well, you'll ask me all about what has happened and I will have to go through it all again and tell you how I'm not coping … and I'll try really hard not to cry too much, so I don't feel like a complete idiot … and my doctor said that getting it all out might be helpful and that you'd be able to give me some ideas about how to cope". That is, her response will most likely be based on her view of what the problem is ("I'm not coping") and/or on what she hopes the therapist will do ("You'll give me some ideas"). Nothing in this invites Sarah to even begin to consider the possibility that things could be different.

However, the question, "How will you know that coming here today has been helpful for you?" is a version of "What will be different that would tell you that coming here has been helpful?". Thus, not only is it a question about the **results** of the session rather than about the session itself, it is also a question that introduces the notion that things might be different. "What brings you here?" (what's the problem?) or "What needs to happen here?" invite responses in terms of the problem and what has happened. They are questions that are backwards-looking. "How will you know …?" is a forward-looking question that points to (the possibility of) change.

When Sarah says, "I want my life back", that opens the possibility of a conversation about things being different, as she begins to build a picture (albeit, a tentative one at this stage), of "What will be happening **when** you have your life back?".

It is also worth noting in this example that the high level of distress did not alter the basic structure of the therapist's exploration. The client's distress clearly affected the process of the session (particularly the pacing) but not the basic structure. There were few overt statements of empathy; indeed, given the unimaginably horrendous experience the client had been through, almost any statement of empathy risked sounding trite. The session shows profound empathy on the part of the therapist; however, little of it was verbal. After the initial acknowledgement, the empathy is conveyed in the silences. Empathy is expressed in the therapist's thorough acceptance of Sarah's distress and in her willingness to sit and wait before gently resuming the exploration.

Note also the therapist's alertness for anything that may convey to Sarah indications of her own competence. Sarah's view is, "I'm not coping", and one of the examples she provides is her inability to go anywhere without her husband accompanying her. The therapist noticed, and is able to draw Sarah's attention to the fact, that Sarah had been on her own in the waiting room. She highlights this through the gentle comment, "Really? I guess I'm wondering how you were able to do that … to come by yourself.".

ANOTHER EXAMPLE[3]

Therapist:	Thank you for coming tonight. I understand that your mother made the appointment for you … that she wanted you to come … and that you didn't necessarily agree with her.
Sam:	No … that's right … I've only come 'cos she was on at me to see someone … I told her that no-one has been able to help … but I figured maybe if I came along it might shut her up a bit.
Therapist:	Okay … so your Mum was keen you should come … you weren't so sure … well, I appreciate you making the effort to come, then. … Yes … I want to thank you for coming. I hope it will turn out to be helpful for you. Of course, there's no guarantees about that. What I can guarantee you is that I will do my best … and I'm sure you will too … and together we'll see where we end up. So … how do you think you will know that coming along and talking to me turns out to be helpful for you?
Sam:	*[Long silence … finally just shrugs shoulders]*
Therapist:	Okay … what do you imagine might be one thing that would be different … when you leave here … that will tell you that coming and talking to me had been useful for you?
Sam:	*[Silence … big sigh]* I … I … I don't know.
Therapist:	You leave here, and you're on your way home … what might be different for you that would make you think "yeah … talking to that guy was helpful"?
Sam:	Helpful? How could this be helpful? *[Pause]* I mean … oh … I don't know.

3 . The therapist was Michael Durrant. From Durrant (2009)

Therapist:	Let's just say that you go home and later tonight, your Mum rings you … and she says, "Did you go?" … and you say, "yes, Mum, I went." … and she says, "So, was it a complete waste of time?" … and you say, "Well … no … actually, it wasn't." … What would be different that would make you say that to your Mum?
Sam:	*[Thinking hard]* Well … maybe … if I thought that maybe there was some point.
Therapist:	Some point … you mean some point to coming?
Sam:	No … some point to being here … some point to being alive.
Therapist:	Oh, okay. And what do you think might be different that would make you think that … that maybe there's some point?

Best hopes

My colleagues in the BRIEF group in London have their own variant of the common project question. They begin the therapy by asking, "What are your best hopes for coming here?" (George et al., 2001) or, "What are your best hopes from this therapy?" (Shennan, George, Ajmal, Ratner, & Iveson, 2008).

> *Identifying what the client wants from the therapy (or session, meeting, work together, etc.) begins the process of "getting down to business". Asking, "What are your best hopes from our work together?" invites the client to talk straight away about outcome. It means that we are being careful to establish what they are commissioning us to do. There is no assessment procedure in solution focused work. Our approach is always based on what the client wants from the work. (George, Iveson, Ratner, & Shennan, 2009, p. 9)*

They comment that this question orients the discussion away from "the problem" and towards what clients want to be different (elsewhere referred to as their "preferred future") and they comment that the question contains an assumption of motivation.

"What are your best hopes for coming here?" seems like a question that might encourager a focus on the therapy process rather than on the client's desired changes. Indeed, George and his colleagues comment:

> *It is possible that "What are your best hopes from this meeting?" is a more useful question than "What are your best hopes for this meeting?" The former implies that what is important is to know what differences are being looked for outside of the therapy, while the latter perhaps invites the client to give an agenda of problems to be discussed in the meeting.(George et al., 2009, p. 9)*

"What are your best hopes **from** this therapy?" is more like the Common Project question; although it is not a form of words that "flows" easily for me[4]. Nonetheless, the "best hopes" question is clearly another question that is about hoped-for change rather than about the problem.

Shennan et al (2008) propose a sequence of questions —

- What are your best hopes from [this session]?
- How would you know if these hopes are realised?
- What are you already doing that might in some way contribute to these hopes being met?

We will see, when we discuss "The Miracle Question" in Chapter 7, that this is a VERY similar sequence of questions, designed to orient our work to how the client wants things to be, and to where he or she is ALREADY towards that. Chapter 7 will also discuss, "but what when they say they want something that is unrealistic?"

4. However, perhaps this doesn't matter! Guy Shennan, from BRIEF, told me: "I was once talking to a Swedish social worker and he said that, when he translated this question into Swedish, it sounded weird. I told him not to worry, it sounds weird in English too. He emailed me a few weeks later, saying that he was just using it translated straight and it was working well!" (Shennan, personal communication, 2009). So, perhaps what matters is that we ask questions that orient clients' thinking towards how things might be different rather than that we ask questions that "flow" okay for us!

A SCHOOL MEETING AND BEST HOPES[5]

Billy, a student in Year 7, had been rather wild on the school camp, running around at 3 AM, swearing and abusing teachers. Following the camp, Billy's parents were summoned to attend a meeting to discuss his behaviour.

The parents, especially Mum, were obviously anxious, pacing up and down in the school foyer. The Deputy Principal, who was to chair the meeting, was clear that everyone involved had strong feelings about the situation. He asked me about how we should run the meeting. I said, "It's always good to start by asking what everyone's best hopes are for our meeting together today?"

We assembled for the meeting — the Deputy Principal, Billy's parents, the Year 7 Coordinator and me. The Deputy looked at his notes and said, "Well thanks everyone for coming. I'd like to start by asking everyone what your best hopes are for our meeting today?"

Mum leaned forward and slammed her hand down on the table. "Well, I'd like to know what your agenda is!" The Deputy looked momentarily ruffled and then, gathering himself, said, "Um, oh well, the first thing on our agenda is to find out what everyone hopes will come from our meeting today".

Dad eased mum back into her chair and said, "Well I guess we'd like to know how we can move forward from this"; to which the Deputy was able to say, "That's great, because that's what we want, too.".

Everyone agreed we did want to work out how to move forward. The Year Coordinator added that he wanted the parents to understand how difficult Billy's behaviour had been. The parents were able to nod in agreement and the discussion of difficulties proceeded without defensiveness or blame.

Billy's parents had come to the meeting (probably) assuming they would be receiving some lecture on what their child had done wrong. The "best hopes" question immediately shifted the focus to the outcome we are hoping for.

"We'd like to know how we can move forward from this" is an outcome statement rather than a problem statement. It is also a statement that allows parents and school to agree that we are heading towards a common goal.

5. This example is from Ian Johnsen, who was at that time school counsellor in a high school.

Thus, no matter what aspect of the misbehaviour we were discussing, the context of our discussion was now that we had agreed on a common project; that is, that we wanted to figure out how to move forward.

What about the therapeutic relationship?

Nothing I am suggesting here changes what we know — that clients need to feel heard and understood. It would be silly to dispute that. However, my suggestion is that we do NOT automatically assume that the long, empathic exploration of the problem is the only way for people to feel heard.

There is ample research evidence that the therapeutic alliance or relationship is an essential ingredient of successful therapeutic outcome and that the quality of the therapeutic alliance probably contributes more to the success or otherwise of therapy than does the particular model the therapist uses (for example, (Bachelor & Horvath, 1999)). Much writing about Solution-Focused Brief Therapy has perhaps not emphasised the importance of the relationship; however, this does not mean that it has ever really been ignored or considered trivial. Indeed, quite apart from the research about the contribution of the relationship to therapy outcome, all good therapists of whatever theoretical persuasion know that engaging the client in a therapeutic relationship or alliance is crucial. Without it, any kind of talking therapy cannot proceed.

Both the *Macquarie Dictionary* and the *Oxford English Dictionary* define the term *relationship* in terms of *connection*. After those definitions that relate to connections by blood or marriage, or a sexual relationship, comes the following: "A personal relation of … common interest, or action" (OED Online, 1989). Similarly, the term *alliance* (often used in terms of *the therapeutic alliance*) is defined as a "Combination for a common object" (OED). Thus, it is important to remember that the relationship, while of crucial importance, is nonetheless NOT the end in itself of our interactions with our clients. We have a relationship or connection with our clients not because of blood or family ties, nor because of intimacy, friendship or shared personal or sporting activity. We have a relationship with our clients because of a common object or purpose. Therapy is a

purposeful activity and our relationship with our clients makes sense only in the context of that purpose.

Therefore, the relationship is important throughout the whole therapeutic encounter. I don't find it helpful t think of "relationship building" as a somehow separate part of the therapy process. In particular, it can be dangerous to think of "establishing the relationship" as a discrete "stage" or phase of the therapy process. Many therapy approaches have been explained in terms of phases or stages, including "the joining phase" (Minuchin, 1974) or "the engagement stage". The notion of "the joining phase" suggests that joining, or establishing the therapeutic relationship, is something one does first, before embarking on the therapy process in proper. Miller, de Shazer and De Jong (2001) suggest that Solution-Focused Brief Therapy is not a step-by-step process of moving from one clearly defined stage to another. They describe how Solution-Focused Brief Therapy might rather be thought of as an evolving conversation that reflects a particular kind of "language game[6]". Thus, a particular kind of language game, or conversation, will promote a particular kind of relationship. For example, when you consult your doctor, you and the doctor employ a particular kind of language game. This means that the conversation develops particular doctor-patient characteristics and it fosters, in that context, a particular kind of relationship. That is, no matter how well you may know your doctor personally, the conversation in that particular context will still promote something that has characteristics of a "doctor-patient" relationship. If, on the other hand, you meet your doctor at the dinner party of a mutual friend, your conversation will inevitably have different characteristics. In that particular context, a different language game will promote a different kind of relationship.

6 . The term "language game" comes from the philosopher Wittgenstein and refers to the system, structure and context of any particular language use within the context of daily life. It includes the idea that language is not just words but includes gestures, facial expressions and so on and occurs within a particular context. In particular, it includes the notion that the language game determines how the participants construe or construct their relationship. Readers should not be put off by the use of the term "game" — this is not about a deliberate performance or strategy. Rather, it is a way of talking about language-in-context, which determines how the relationship develops.

In a therapist-client interaction based on a problem-focused language game, the relationship will inevitably develop in a particular way. In this kind of situation, a language game is developed around one person who is the expert and assesses the problem brought by the other person, who is unable to deal with it themselves, and then decides how to solve the problem for that person. No matter how warm and friendly the therapist might be, this kind of language game will inevitably lead to a particular kind of therapeutic relationship. In Solution-Focused Brief Therapy, therapists and clients employ a different language game and, in that context, a different kind of relationship is constructed.

> *The emphasis in solution-focused therapy interviewing … is on discussing how clients want their lives to be different and on identifying existing client strengths, knowledge and resources that clients might use to create desired change (Miller et al., 2001, p. 398)*

An interview that begins with an exploration of "how will you know that talking to me has been helpful?" is beginning by discussing how the clients want their lives to be different. Of course, I (the therapist) cannot know beforehand how this person wants his or her life to be different. Therefore, immediately I cannot be "the expert" and the relationship may develop in a different direction.

> *The therapeutic relationship is a negotiated, consensual and cooperative endeavour in which the solution-focused therapist and client jointly produce various language games focused on a) exceptions, b) goals and c) solutions (de Shazer, 1985, 1988). All of these are negotiated and produced and therapists and clients misunderstand together, make sense of and give meaning to otherwise ambiguous events, feelings and relationships. In doing so, therapists and clients jointly assign meaning to aspects of clients' lives and justify actions intended to develop a solution. — (de Shazer, 1991, p. 74)*

Some may argue that deliberate "relationship building" is important to avoid resistance in clients. We might suggest, on the other hand, that what we sometimes call "resistance" is more likely if the therapist is clearly being

the expert, telling the client what he or she is doing wrong and what he or she needs to do (indeed, those behaviours we call "resistance" are probably the most reasonable and logical response to a therapist taking this position — again, regardless of how much the therapist does this in a warm or friendly manner). A Solution-Focused conversation may encourage a different sort of response.

> *Focusing on strengths, exceptions, solutions and a more favourable future inspires clients (and therapists) and promotes "empowerment". The therapist-client relationship is evolving and dynamic. Flexibly renegotiating goals, and appreciating and working* with *clients' sense of their situations maintain therapist-client cooperation and vitiate the concept of resistance. (Hoyt & Berg, 2001, p. 206)*

Indeed, it has been suggested that Solution-Focused conversations implicitly reflect those aspects of therapy that have traditionally been seen to foster the therapeutic relationship — empowerment, mutuality, respecting the uniqueness of the individual, and so on (in this case described in terms of social work values but hopefully equally relevant to other disciplines).

> *A Solution-Focused approach is not just a grouping of techniques or interventions. It is a way of thinking about who people are, what therapy is and how change occurs. This approach is not merely a model, it is a philosophy — a philosophy that for many clinicians requires and epistemological change. A solution-focused philosophy is deeply rooted in traditional social work values and beliefs such as self-determination and the uniqueness of the individual in fostering his or her own potential, as well as the social work practice belief that the therapy relationship is one of mutuality and purpose. … For us, solution-focused therapy is a way to operationalize those most basic social work traditions (Peller & Walter, 1998, p. 71).*

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