OUTCOME RESEARCH

COMMON FACTORS

CLIENT AND EXTRATHERAPEUTIC FACTORS

- The client is the single most important contributor to outcome
- Be mindful of the client's contribution to change
- Explore the client's strengths, abilities, and resources
- Tap into internal competencies
- Tap into external resources
- Be changed-focused
- Tap into clients' worlds outside of therapy—including spontaneous, chance events

RELATIONSHIP FACTORS

- Client's perceptions of therapists as being empathic and nonjudgmental are most important
- Accommodate treatment to the client's view of the therapeutic relationship
- Accommodate the client's goals
- Accommodate treatment to the client's motivational level

EXPECTANCY AND PLACEBO FACTORS

- Hope and the expectancy for change are essential factors that mental health professionals can either promote or diminish
- Opening moments and interactions are important
- Explore the possibilities for change without minimizing pain and suffering
- Use language that promotes hope
- Be mindful of personal biases
- Highlight clients' sense of personal control
- Orient treatment toward the future
- De-person-alize clients' complaints

MODEL AND TECHNIQUE FACTORS

- Choose models or techniques that fit with your clients and reflect the common factors
- Use techniques and interventions that are consistent with clients' stages of change
- Collaborate with clients on "tasks"

RESOURCES

Bergin, A. E., & Garfield, S. L. (Eds.). (1994). *Handbook of psychotherapy and behavior change* (4th ed.). New York: Wiley.

Bertolino, B. (1999). *Therapy with troubled teenagers: Rewriting young lives in progress*. New York: Wiley.

Bertolino, B., & O'Hanlon, B. (2002). *Collaborative, competency-based counseling and therapy*. Boston: Allyn & Bacon.

Bohart, A., & Tallman, K. (1999). *How clients make therapy work: The process of active self-healing*. Washington, DC: American Psychological Association.

Duncan, B. L., & Miller, S. D. (2000). *The heroic client: Doing client-directed, outcome-informed therapy*. San Francisco: Jossey-Bass.

Hubble, M. A., Miller, S. D., & Duncan, B. L. (Eds.). (1999). *The heart and soul of change: What works in therapy*. Washington, D.C.:American Psychological Association.

Miller, S. D., Duncan, B. L., & Hubble, M. A. (1997). *Escape from Babel: Toward a unifying language for psychotherapy practice*. New York: Norton.

Wampold, B. E. (2001). *The great psychotherapy debate: Models, methods, and findings*. New Jersey: Lawrence Erlbaum Associates.

Therapeutic Collaborations Consultation & Training
Bob Bertolino, Ph.D.
1237 Saddlemaker Drive Saint Charles, Missouri 63304 USA
Phone/Fax 636.300.3885 E-Mail bertolinob@cs.com
Website www.bobbertolino.com

POSSIBILITY, COLLABORATIVE, & CHANGE-ORIENTED IDEAS

Clients as Agents of Change
The client is the single most important contributor to therapeutic outcome. People have abilities, strengths, and resources that can be helpful in solving problems and resolving conflicts. This is not suggesting that they have *all* the competencies that they will ever need. This is not the "hidden gem theory," which holds that clients have untapped reservoirs with answers to every problem in life. Instead, people are seen as both in the process of learning and as having competencies—internal and external resources that have been helpful in the past, in similar or different contexts in relation to presenting concerns, and can be utilized in the present and future. Internal competencies include individual strengths and abilities while external resources relate to family, friends, community, religious, and other potential relational contributors. Viewing clients as agents of change means acknowledging and attending to the hardships that people face while simultaneously focusing on the possibilities for change that exist.

Honoring the Therapeutic Relationship and Alliance
The therapeutic relationship *is* treatment. Client ratings of the relationship are the *most* consistent predictor of improvement (Duncan & Miller, 2000; Gurman, 1977; Lafferty, Beutler, & Crago, 1989). The strength of the therapeutic bond is not highly correlated with the length of treatment (Horvath & Luborsky, 1993). There can be an instant bond between a client and practitioner. The amount of time it takes for people to feel comfortable in relationships varies and is highly contingent on their perceptions. The therapeutic alliance is a more encompassing term that emphasizes a collaborative partnership between clients and practitioners. Clients are consulted about their preferences, goals, and methods for accomplishing those goals. Negative outcome is often traced to clients being left out of therapeutic processes.

Inviting Clients' Theories
Theories do not drive therapy, clients do. They are the engineers of change. It is important to invite clients to share their ideas as to what they believe are the influences on their concerns, and could perhaps be resources for future change. Although "problems" can be influenced by family, social relationships, genetics, biology, cognition, culture, race, society, gender, religion/spirituality, economics, and so on—what is most important is how clients understand their concerns. Moreover, it is essential that therapists honor clients' theories. Therapists should work to match clients' theories by using therapeutic processes and practices that are consistent with the ways clients view the world. To further honor clients' theories, we have conversations with clients about how they feel their problems developed, what has been tried to resolve them and to what degree those efforts have or haven't worked, what they've considered but haven't tried, and what they might consider in the future to attain the change they desire.

A Change-Orientation
Research indicates that the average length of time that clients attend treatment is 6-10 sessions (Doherty & Simmons, 1996; Garfield, 1989; Koss & Butcher, 1986). Further, Miller et al. (1997) wrote that "all large-scale meta-analytic studies of client change indicate that the most frequent improvement occurs early in treatment" (p. 194). Studies have shown that most major positive impact in treatment happens during the first 6-8 sessions, followed by continuing but decreasing impact over the next 10 sessions (Smith, Glass, & Miller, 1980; Talmon, 1990). To work efficiently in searching for openings with possibilities for solution and change is the respectful, practical, and ethical position. Thus, it is essential that practitioners work to maximize the effectiveness of each session with an eye on helping clients to resolve their concerns as quickly as possible. It is not the number of sessions that is most important, but collaborating with clients to determine where they want to go and when goals have been met.

Goals, Meaning, Purpose, and Outcomes

One of the best predictors of negative outcome is a lack of structure in therapy. This does not mean that therapy follows a flow chart. Instead structure translates to having some sense of direction including learning about clients' concerns, what they would like to have change, and how they will know when that change has occurred. Some clients will struggle with the term "goals" and will resonate more with trying to find "meaning" and/or "purpose." It is important to match the language that clients use and work within their worldviews. At the same time, goals, meaning, and purpose should in some way translate into clear, observable actions on the part of clients. This is essential, as clients will often use vague terms that do not clearly define their concerns. It is up to practitioners to work with clients to clarify what they mean by their words, so realistic and achievable ends can be worked toward. Outcomes are distinguished from goals, meaning, and purpose in that they indicate an improvement in overall functioning (i.e., individually, interpersonally, socially, etc.).

Means and Methods

All therapy approaches involve the use of methods and techniques. The effectiveness of methods and techniques is highly contingent on the degree to which they match clients' ideas about their concerns or problems and the means and/or methods necessary to resolve them. Means, methods, and techniques ought to arise out of client-practitioner interactions and make use of the general effects that are the most significant contributors to outcomes. If therapists have ideas about methods that may assist in facilitating change, they should be *offered*, not imposed on clients. That is, clients determine what makes most sense for them and are more likely to take action in their lives when means and methods match their personal theories.

Adapted from:

Bertolino, B. (in press). *Change-oriented therapy with adolescents and young adults*. New York: Norton.

Bertolino, B., & O'Hanlon, B. (2002). *Collaborative, competency-based counseling and therapy*. Boston: Allyn & Bacon.

References

Doherty, W. J., & Simmons, D. S. (1996). Clinical practice patterns of marriage and family therapy: A national survey of therapists and their clients. *Journal of Marital and Family Therapy*, *22*(1), 9-26.

Duncan, B. L., & Miller, S. D. (2000). *The heroic client: Doing client-centered, outcome-informed therapy*. San Francisco: Jossey-Bass.

Garfield, S. L. (1989). *The practice of brief psychotherapy*. New York: Pergamon.

Gurman, A. S. (1977). The patient's perceptions of the therapeutic relationship. In A. S. Gurman & A. M. Razin (Eds.), *Effective psychotherapy* (pp. 503-545). New York: Pergamon.

Koss, M. P., & Butcher, J. N. (1986). Research on brief psychotherapy. In A. E. Bergin & S. L. Garfield (Eds.), *Handbook of psychotherapy and behavior change* (3rd ed.) (pp. 627-663). New York: Wiley.

Lafferty, P., Beutler, L. E., & Crago, M. (1989). Differences between more and less effective psychotherapists: A study of select therapist variables. *Journal of Consulting and Clinical Psychology*, *57*, 76-80.

Luborsky, L., Singer, B., & Luborsky, L. (1975). Comparative studies of psychotherapies: Is it true that "everyone has won and all must have prizes"? *Archives of General Psychiatry*, *32*, 995-1008.

Miller, S. D., Duncan, B. L., & Hubble, M. A. (1997). *Escape from Babel: Toward a unifying language for psychotherapy practice*. New York: Norton.

Smith, M. L., Glass, G. V., & Miller, T. I. (1980). *The benefits of psychotherapy*. Baltimore, MD: Johns Hopkins University Press.

Therapeutic Collaborations Consultation & Training
Bob Bertolino, Ph.D.
1237 Saddlemaker Drive Saint Charles, Missouri 63304 USA
Phone/Fax 636.300.3885 E-Mail bertolinob@cs.com
Website www.bobbertolino.com

COLLABORATIVE THERAPY

Clients and mental health professionals are both experts. Clients are experts on their lives and experiences. They know what they've been through and what it feels like. Clients are also familiar with what they've tried to resolve their concerns. They know what hasn't worked, what has (to any degree) and what might work in the future. Mental health professionals are experts on creating a context that facilitates positive change. Through warmth, unconditional positive regard, empathy, and careful attention, clinicians can acknowledge and validate clients' internal experience and simultaneously explore possibilities for change in the directions of clients' goals. A collaborative therapy is also one that:

- Clients are regularly part of treatment processes. They are consulted about:
  - directions, goals, meaning, purpose, and outcomes;
  - methods for achieving those goals and outcomes;
  - diagnostic procedures;
  - case notes (and they are written terms that are understandable to clients).

- Therapists and mental health professionals ask questions and make speculations from a non-authoritarian way, giving clients ample room and permission to disagree. If clinicians have ideas they are shared with clients and are presented not as truths or right directions, but as personal impressions, impressions, and possibilities. Although clients may be offered many options, they choose those which are right for them. In doing so clients teach clinicians more about what still needs to be learned about their concerns and ways of going about resolving them.

- Mental health professionals are wary of "theory countertransference." This is evident when a clinician continues to "discover" the same problems in client after client (e.g., "unresolved losses," "separation anxiety," "attachment disorder," etc.). This also means not imposing one's beliefs and therapeutic values on clients' lives.

- Other helpers are given respect and no attributions of bad intentions or wrong approaches are implied regarding their treatment. They are invited into cooperative relationships by inquiring about their views of the situation and what outcomes they are expecting from treatment. If they are willing to say, you can ask them about how you might help with or at least not interfere with their treatment. This does not mean that one has to accept or support everything other helpers do. The first loyalty is to clients. Stories of impossibility, blame, invalidation, and determinism are gently and subtly challenged by acknowledging their possible validity and introducing alternate possibilities.

- Clients are given opportunities to comment and provide feedback on the processes of helping. In addition, with consent, their expertise may be shared with others, elevating their status from passive, needy recipients to active, expert contributors.

FOUR PATHWAYS TO IMPOSSIBILITY

Just as clients can become stuck by viewing their situations as impossible and unchangeable, professionals can fall into the same trap. Below are four pathways that practitioners need to guard against in order to be helpful to their clients.

➡ Anticipation of Impossibility

Through language, diagnosis, and descriptions practitioners can create *problems* or situations that are unsolvable and suggest impossibility. When mental health professionals anticipate impossibility they often begin to label their clients as resistant, unmotivated, and unwilling to change. This is evidenced through practices that inhibit change as opposed to promoting it.

➡ Theory Countertransference

Inherent to assessment procedures and therapeutic methods are ideas that can close down pathways of possibilities. While traditions are important in all human pursuits, they can also inhibit change and even have damaging consequences. Theory countertransference represents clinicians' loyalties to theoretical constructs. Unfortunately, some practitioners are convinced that the observations they make during the assessment process are "real" and objective. They are certain they have discovered *real* problems. In its strictest, technical meaning, countertranference refers to an emotional, largely unconscious process, taking place in the therapist and triggered in relationship to the client, that intrudes into the treatment. A similar process of projection can take place in the theoretical realm, with the therapist unconsciously intruding on the client with his or her theoretical biases and unrecognized assumptions. It's important that therapists are aware of how their theoretical constructs influence the content, process, and direction of therapy. Truly, therapists will have ideas, thoughts, and theories. The same is true with clients, outside helpers, and so on. Clients' points of view must be acknowledged from the start of therapy and throughout the process or the situation can close down quickly. The premise here is to remain in collaborative relationship where clients' theories are honored.

➡ Practitioners Repeating Unhelpful Methods, Techniques, and Practices

Oftentimes practitioners fall into the habit of repeating methods even though they fail to facilitate positive results. They do more of the same despite the fact that what they are doing is not effective. Once again, when clients do not respond favorably to clinicians' preferred methods they are sometimes considered resistant, not ready to change, and so on. Keep in mind that it's practitioners who fall in love with methods, not clients.

➡ Inattention to Clients' Motivation

The single best indicator of outcome is the client's participation in therapeutic processes. Too often practitioners work on their goals and what they want to see change as opposed to tuning into clients' ideas. It is not an issue of whether or not the client is motivated. The question is: What the client is motivated for?

Therapeutic Collaborations Consultation & Training
Bob Bertolino, Ph.D.
1237 Saddlemaker Drive Saint Charles, Missouri 63304 USA
Phone/Fax 636.300.3885 E-Mail bertolinob@cs.com
Website www.bobbertolino.com

POSSIBILITY-ORIENTED ASSESSMENT

It is commonplace in many settings to use a specific assessment to gather information. Some places will require only that minimal information such as demographic data and a brief social history be obtained. Others will require in-depth and lengthy procedures using rather complex assessment tools, often leading to psychiatric diagnosis. From a possibility-oriented perspective, there are two ways of using assessment:

1. *Formal Assessment* – This involves attention to both the difficulties that people experience, as well as their competencies. Most assessment instruments maintain a problem or pathology focus. Collaborative, competency-based clinicians attend to the difficulties that people face and also explore competencies such as abilities, strengths, and resources that may be of assistance is resolving concerns and complaints.

2. *Ongoing Assessment* – This begins with the first session and ends with the termination of counseling. From the opening moments of treatment, counselors attend to the therapeutic relationship and learn clients' theories of change. In addition, they begin to use language in a way that opens up possibilities. The third important element is counselors begin to work with clients to create clearly delineated goals/preferences and outcomes. In this way, assessment is ongoing and continues throughout counseling, as established goals/preferences are met, modified, and changed. People and their concerns are not static. Assessment should be flexible in meeting the needs of people at all points of counseling and in:

    - ⇨ facilitating the therapeutic relationship and alliance.
    - ⇨ building on or creating hope for the future.
    - ⇨ allowing clients to tell their stories.
    - ⇨ learning clients' ways of using language.
    - ⇨ learning about clients' concerns and complaints.
    - ⇨ exploring clients' strengths, abilities, and resources.
    - ⇨ learning clients' theories of change.

Should a particular setting require that a certain type of problem-focused or pathology-based assessment be completed, a respectful and collaborative way is to let the adolescent and family members know that every client goes through the same or similar procedure. This can normalize the process. Here are a couple of examples:

> *If it's okay with you, I'd like to ask you some questions that we ask of all people who come to see us. The information you give will help us to understand what you're concerned about and how that's affected you, what you'd like to see change, what's worked and hasn't worked for you in trying to manage your concerns, and how we can be of help to you. And as we proceed, if you feel like or think we've missed something please be sure to let us know. We want to make sure that we fully understand your needs. How does that sound?*

> *There are some questions that I'd like to ask you that we ask of everyone who comes here. The questions will help me to understand what's happening with you or in you life that's of concern. Once we get finished with those questions, we'll move on to some others that will tell me more about what you do well and what has or might work for you in the future regarding your concerns. How does that sound?*

Some assessments may be problem or pathology-focused, but allow room for the therapist to ask other questions that introduce some sort of balance by working to elicit and evoke competencies and resources. In these cases, information can be gathered about strengths, abilities, and resources in addition to problem areas. Even when the information seems to be very problematic, the practitioner can consider, "What else?" and ask exception questions. Such questions ask for information about when a problem is less dominating, occurs less frequently, is absent, and so on. In turn, the information gathered can form building blocks for client change. Next are some examples of questions that search for exceptions.

The Concern/Problem

- *It seems that when this problem is happening things are pretty difficult. When does the problem seem less noticeable to you? What is everyone doing when it's less noticeable?*
- *When does the problem appear to happen less?*
- *What do you suppose keeps your son/daughter from going off the deep end with trouble?*
- *What is your son/daughter doing when he/she is not in trouble?*
- *Tell me what it's like when the problem is a little less dominating.*
- *What's it like when things are a bit more manageable?*
- *When do you seem to get more of an upper hand with _____ (the problem)? How do you do that?*
- *When things are going poorly, how does your son/daughter usually start/stop their behavior? What do you do to help the situation that's different?*
- *What have others failed to notice about your situation or problem?*

Work/Employment

- *How did you come to work at your current place of employment?*
- *How did you get yourself into position to get the job?*
- *What do you think your employer saw in you that might have contributed to your being hired?*
- *What have you found to be most challenging or difficult about your job?*
- *How have you met or worked toward meeting those challenges/difficulties?*
- *What keeps you there?*
- *What skills or qualities do you think you employer sees in you?*
- *What qualities do you think you possess that are assets on the job?*
- *(if self-employed) How did you have the wherewithal to start your own business?*
- *(if unemployed) What kind of employment would you like to see yourself involved with in the future?*
- *What would be a first step for you in making that happen?*

Education/School

- *How did you manage to make it to/through _____ (9th grade, high school, trade school, junior college, a 4-year university, two years of college, graduate school, etc?)*
- *What qualities do you possess that made that happen?*
- *What did you like best about school?*
- *What did you find most challenging/difficult about school?*
- *How did you manage any difficulties that you many have encountered while in school? (e.g., completing homework/assignments, tests, getting to school on time, moving from one grade to another, teacher/classmate relationships, sports, etc.)*
- *In what ways did school prepare you for future challenges?*

Family/Social Relationships

- *Who are you closest to in your _____ (life, family, etc)?*
- *What do you appreciate most about your relationship with _____?*
- *What would he/she/they say are your best qualities as a _____ (friend, husband/wife, father/mother, son/daughter, uncle/aunt, grandparent, colleague, etc?*
- *How is that helpful for you to know that?*
- *What does it feel like to know that?*
- *Which relationships have been more challenging/difficult for you?*
- *How have you dealt with those challenges/difficulties?*
- *Whom can you go to for help?*
- *Who has made a positive difference in your life? How so?*
- *What difference has that made for you?*
- *When are others most helpful to you?*

Hobbies/Interests

- *What do you do for fun?*
- *What hobbies or interests do you have or have you had in the past?*
- *What kinds of activities are you drawn to?*
- *What kinds of activities would you rather not be involved with?*
- *What would you rather do instead?*

Previous Treatment Experiences

- *What did you find helpful about previous therapy _____ (individual, couples, family, group, etc.)?*
- *What did the therapist do that was helpful?*
- *How did that make a difference for you?*
- *What wasn't so helpful?*
- *(if currently or previously on psychotropic medication) How is/was the medication helpful to you?*
- *What, if anything, did/does the medication allow you to do that you wouldn't have otherwise been able to do?*
- *What qualities do you possess such that you were/are able to work with the medication to improve things for yourself?*

Police and Court History

- *How come your not already locked up?*
- *How have you managed to keep from getting into further trouble with the police?*
- *What's the longest you've gone without being in trouble with the law? How did you do that?*

Notice that these questions do not inquire about extremes. They don't ask: "When don't you have the problem?" That's too big a leap for most people. Instead, these questions work to elicit small exceptions. All we are searching for is a thread of hope or a ray of light. That can be enough to get the ball rolling early on. By asking exception-oriented questions along with the ones that are required on the assessment tool, the interviewer can gain valuable information from the client. In addition, hope can be injected into what can often be a very negative experience. If therapy involves focusing only on everything that is or has gone wrong with a person, it can be further invalidating and a replication of what has already heard on countless occasions. There are many areas that therapists can ask exception-based questions during an initial assessment. At the same time, because assessment is an ongoing process, these types of questions can be helpful at any point during therapy.

DEEP LISTENING

- Sit with the person's pain and suffering with compassion instead of offering positive stories or trying to fix, give advice or suggestions. Be willing to do nothing, just be with, acknowledge and honor the person, his or her pain and suffering. Just having told one's story can often be powerfully therapeutic.

- Attend to the person you are sitting with and his or her story and experience rather than your idea of the truth or what he or she should experience or do.

- Be aware of the bias many if us have and our culture has toward redemptive stories. Do not try to change, rewrite, reframe, or invalidate the person's non-redemptive, non-happy-ending story.

- Give credit for small or large efforts, endurance, or strength in facing challenges without being patronizing.

- Keep one foot in acknowledgment and one in possibilities, but do not insist on always speaking about possibilities.

- Avoid platitudes:
  - Everything will work out.
  - God doesn't give you more than you can handle.
  - You are going to be all right.

- Avoid glib explanations:
  - Why did you create this?
  - I wonder what you are meant to learn from this?
  - What part of you needs or benefits from this pain?

- Speak to the complexity of the situation, including seeming contradictions:
  - You can't go on suffering like this and you don't want to die.
  - You want to give up and you don't want to give up.

2000 – Adapted from Bill & Steffanie O'Hanlon

Therapeutic Collaborations Consultation & Training
Bob Bertolino, Ph.D.
1237 Saddlemaker Drive Saint Charles, Missouri 63304 USA
Phone/Fax 636.300.3885 E-Mail bertolinob@cs.com
Website www.bobbertolino.com

ESTABLISHING DIRECTIONS AND GOALS

1. **Listen and attend to clients' stories by using acknowledgment and validation.**

2. **Match clients' use of language by tuning into their words, statements, and phrases. Listen closely to what they attribute their concerns (e.g., familial, relational, behavioral, biological, cultural, etc.).**

3. **Create a focus.** To do this we want to find out: What needs to change? Determining what needs to change means creating a goal that is both achievable and solvable. Achievable goals consist of clients' actions or conditions that can be brought about by their actions.
   - What people complain about is not always what they want to change. Sometimes clients will just want to be reassured that what they are doing is "normal" or reasonable. They may just want to heard and acknowledged. Thus, in gaining a focus the practitioner must make sure that the complaint is in fact what clients want to see change.
   - In determining what needs to change, we want to use action-talk. This involves having clients describe how they "do" the problem. This allows clients to move away from vague descriptions and non-sensory-based words and phrases about situations toward concrete terms and solvable problems.
   - Action-based language can also be helpful with the translation of psychiatric labels into process or action descriptions. Again, this will assist the practitioner and client in the creation of a solvable problem.
   - The therapist's job is to work collaboratively with clients to negotiate realistic and achievable goals. In most cases there will be a different agenda and at least one complaint for each person. When there are multiple complaints we try to acknowledge and address each complaint and combine them into mutual complaints and goals on which to focus our inquiries and interventions. Acknowledgment, tracking, and linking are commonly used to coordinate complaints and goals. First, each person's position is acknowledged and re-stated in the least inflammatory way possible that still acknowledges and imparts the feeling and meaning.

4. **Determine how it will be known when things are better.** When it's clear what needs to change, we want to know what the change will look like when it happens (if it isn't already). We ask: "How will you know when it's better?" We refer to *action-talk*. This can help to translate vague descriptions such as "She'll be good" or "He won't be out of control" into clear, behavioral descriptions.

- If people seem to struggle with generating a view of what the change will look like in action terms, it can be helpful to give multiple choice options. For example, a therapist could say, "Will she be doing _____ or _____ or _____?" The person can either choose one of the choices or come up with a different description altogether.

5. **Determine how it will be known that progress is being made.** People oftentimes will become frustrated or irritable if they don't feel that change is happening. What we want to do is help people to identify "in-between" change. That is, what will indicate that progress is being made? Consider these questions:

- What will be the first sign or indication that things have begun to turn the corner with your situation?
- What's one thing that might indicate to you that things are on the upswing?
- What will you see happening when things are beginning to go more the way you'd like them to go?
- What would have to happen to indicate to you that things are changing in the direction you'd like them to change?
- How will you know when the change you are looking for has started?
- What is happening right now with your situation that you would like to have continue?

Therapeutic Collaborations Consultation & Training
Bob Bertolino, Ph.D.
1237 Saddlemaker Drive Saint Charles, Missouri 63304 USA
Phone/Fax 636.300.3885 E-Mail bertolinob@cs.com
Website www.bobbertolino.com

PATHWAYS TO CREATE CHANGE

EXPERIENCE	CONTEXT	VIEWS	ACTIONS
◗ Feelings ◗ Sense of self ◗ Bodily sensations ◗ Sensory experience ◗ Automatic fantasies and thoughts	◗ Time patterns (Actions) ◗ Spatial patterns (Actions) ◗ Cultural background and propensities ◗ Familial/historical background and propensities ◗ Biochemical/genetic background and propensities ◗ Gender training and propensities ◗ Spiritual/religious ideologies	◗ Points of view ◗ Attentional patterns ◗ Interpretations ◗ Explanations ◗ Evaluations ◗ Assumptions ◗ Beliefs ◗ Identity stories	◗ Action patterns ◗ Interactional patterns ◗ Language patterns ◗ Nonverbal patterns

EXPERIENCE	CONTEXT	VIEWS	ACTIONS
Give messages of acceptance, validation and acknowledgment. There is no need to change or analyze experience as it is not inherently a problem.	Identify unhelpful and helpful aspects of the context, then suggest shifts in the context around the problem (e.g., changes in biochemistry, time, space, cultural habits and influences, etc.).	Identify and challenge views that are: Impossibility Blaming Invalidating Non-accountability or determinism. Also: Offer new possibilities for attention.	Find action and interaction patterns that are part of the problem and that are the "same damn thing over and over." Then suggest disrupting the problematic patterns or find and use solution patterns.

Therapeutic Collaborations Consultation & Training
Bob Bertolino, Ph.D.
1237 Saddlemaker Drive Saint Charles, Missouri 63304 USA
Phone/Fax 636.300.3885 E-Mail bertolinob@cs.com
Website www.bobbertolino.com

POSSIBILITIES FOR FACILITATING CHANGE

EXPLORING CLIENTS THEORIES THROUGH CONTEXT – In every problem involving a contextual element, there are problematic influences as well as solution patterns and competencies. There are propensities that move people toward their goals and those that restrain them. Remember, aspects of context only *influence*, they do not cause problems. We want to search for the exceptions and solution patterns that run counter to the problematic patterns. Here are a few ways of doing this:

1. Learn clients' ideas and beliefs regarding possible influences on concerns, problems, and potential solutions
Consider what influence cultural, ethnic, social, gender, familial, spiritual, political, religious, spiritual, and biological propensities have had on the creation of clients' worldviews including their beliefs, ideas, explanations, interpretations, and so on. Ask clients to explore ways in which these propensities move them toward their goals and ways that they may hold them back from achieving their goals.

2. Tap into social support systems (i.e., community, school, employment, church, friendships, etc.)
This can be individuals or groups of people who have or could be helpful to clients or others.

3. Explore relationships that have made or could make a difference
Find out about people who have played more significant roles in the lives of clients. In recalling these figures clients may be able to shift their views and perceptions. Significant others also can become future resources.

CHANGING PATTERNS OF VIEWING – When clients hold problematic views or attentional patterns our task is to help them to change those unhelpful views to ones that breathe hope and possibilities.

1. Use Language that Promotes Hope
Move from stigmatizing terms and phrases to words that promote possibilities and change. Use competency-based descriptions as opposed to problem-focused ones.

2. Search for Counterevidence, Exceptions, and Unique Outcomes
This involves having the client or other tell you something that doesn't fit with the problematic story. To find counterevidence it's usually best to begin in the present and backward. The reason for this is the more current the evidence the stronger it will be. Sometimes the mental health professional may have to go back a few months, a year, or even a few to find evidence that contradicts the problem story. That's okay. Evidence is evidence. It's easier to evoke or elicit past abilities and competencies than to teach someone something they've never done. In addition, when therapists only teach skills such as those just mentioned, clients and others may only turn to "experts" when future problems arise and downplay or mistrust the significance of their own unique solutions and perspectives.

3. Find Alternative Stories or Frames that Fit the Same Evidence or Facts
Sometimes a client or other's interpretation of another person, event, or situation is closed down and a therapist's interpretation can offer a different point of view and lead to the dissolution of a problematic story. Specifically, when a client or other makes a closed down statement relating a problematic story, the therapist can *offer* an alternative story or interpretation. It is important to use acknowledgement and possibility-laced language in conjunction with an interpretation. The therapist also introduces any interpretation from a position of *conjecture* or wonderment. This is done by prefacing questions with sentence stems such as, "I wonder," "Is it possible," or "Could it be."

4. Search for Resilient Qualities
Explore the qualities that clients possess that allow them to stand up to adversity and manage very difficult situations to any degree.

5. Use Externalizing Language
Separate the person from the problem by exploring the influence of the problem over the person and the person's influence over the problem.

6. Create or Rehabilitate a Vision for the Future with Future Pull
Help clients to get a sense of the future and gain a vision of the outcomes they prefer.

7. Use Self-Disclosure, Metaphor, and Stories
Help to normalize the experiences of clients, promote hope, tap into competencies and resources, and offer possibilities for future changes.

8. Use Reflecting, Consulting, and Conversational Teams
By expanding the therapeutic system multiple views can be offered to clients. Oftentimes, new perspectives that are offered by others lead to the creation of new meanings for clients.

CHANGING PATTERNS OF ACTION AND INTERACTION

1. <u>DEPATTERNING</u> – Find and alter repetitive patterns of action and interaction that are involved with the problem (aspects of context)

➧ **To identify problematic patterns, the therapist wants to attend to the following things:**
➞ How often does the problem typically happen (once an hour, once a day, once a week)?
➞ Find the typical timing (time of day, time of week, time of month, time of year) of the problem.
➞ Find the duration of the problem (how long it typically lasts).
➞ Where does the problem typically happen? (spatial patterns).
➞ What does the person and others who are around usually do when the problem is happening?

Alter, Interrupt, or Disrupt Repetitive Patterns of Action and Interaction Involved in or Surrounding the Problem
- Change the *frequency/rate* of the problem or the pattern around the problem
- Change the *duration* of the problem or the pattern around the problem.
- Change the *time* (hour/time of day, week, month or time of year) of the problem or the pattern around the problem.
- Change the *intensity* of the problem or the pattern around the problem.
- *Interrupt* or otherwise prevent the occurrence of the problem.
- *Add a new element* to the problem.
- *Reverse the direction of striving* in the performance of the problem (Paradox).
- *Link the* occurrence of the *problem to* another pattern that is *a burdensome activity* (Ordeal).

2. <u>REPATTERNING</u> – Find and use solution patterns of action and interaction. Elicit, evoke, and highlight previous solution patterns, abilities, competencies, strengths, and resources. This does not mean trying to convince clients and others of their competencies and abilities. For example, we wouldn't say, "You can do it. Just look at your all your strengths!" This can be very invalidating to people who are stuck. Instead, we want to continue to acknowledge what is being experienced internally and begin to investigate clients' wealth of experience and expertise. Through our questions we work to evoke some sense of competence and experience of solving problems that they already possess.

➧ ***Find out about previous solutions to the problem, including partial solutions and partial successes***
- Tell me about a time when the problem happened and you were able to get somewhat of a handle on it. What was different about that time?
- You mentioned that you usually "lose your temper" and scream at him when he breaks curfew, but you didn't do that last night. How did you do that?

- ***Find out what happens when the problem ends or starts to end***

- How do you know when the problem is coming to an end? What's the first thing that you notice?
- How can others tell when the problem has subsided or started to subside?
- What have you noticed helps you to wind down?

- ***Find out about any helpful changes that have happened before treatment began***

Pre-treatment change can yield important information about how people solve their problems. One way to do this is to ask:

- Many times people notice between the time that they contact us and the time they come in that things already seem different. What have you noticed about your situation?"

- ***Search for contexts in which clients feel competent and has good problem-solving or creative skills***

Even though clients may be experiencing problems in specific areas of their lives, oftentimes they have competencies, abilities, or there are solution patterns in other areas that can be helpful in solving the problem at hand. We want to explore any areas of clients' lives that they feel good about. This can include jobs, hobbies, sports, clubs, or areas of special knowledge or skill that they have that can be tapped into to solve the problem.

- ***Find out why the problem isn't worse***

Sometimes it can be helpful to ask why the problem isn't worse. This can do at least two things. First, it can normalize things for clients when they realize that some people do experience worse situations. Second, it can yield information about what they've done to keep things from deteriorating.

- How come things aren't worse with your situation?
- What have you done to keep things from getting worse?
- What steps have you taken to prevent things from heading downhill any further?
- How has that made a difference with your situation?

- ***Use rituals that promote continuity or connection***

- Continue or restore previous rituals, or create new ones

Sample List of Resources:

Bertolino, B. (1999). *Therapy with troubled teenagers: Rewriting young lives in progress*. New York: Wiley.

Bertolino, B., & O'Hanlon, B. (2002). *Collaborative, competency-based counseling and therapy*. Boston: Allyn & Bacon.

Bertolino, B., & Schultheis, G. (in press). *The therapist's notebook for families: Solution-oriented exercises for working with parents, children, and adolescents*. New York: The Haworth Press.

Bertolino, B., & Thompson, K. (1999). *The residential youth care worker in action: A collaborative, competency-based approach*. New York: The Haworth Press.

Duncan, B. L., & Miller, S. D. (2000). *The heroic client: Doing client-centered, outcome-informed therapy*. San Francisco: Jossey-Bass.

Duncan, B. L., & Sparks, J. (2001). *Heroic clients, heroic agencies: Partners for change*. Ft. Lauderdale, FL: Nova Southeastern University Press.

Hubble, M. A., Miller, S. D., & Duncan, B. L. (Eds.). (1999). *The heart and soul of change: What works in therapy*. Washington, D.C.: American Psychological Association.

Metcalf, L. (1995). *Counseling toward solutions: A practical solution-focused program for working with students, teachers, and parents*. New York: Simon & Schuster.

O'Hanlon, B., & Bertolino, B. (2002). *Even from a broken web: Brief, respectful solution-oriented therapy for sexual abuse and trauma*. New York: Norton. [Paperback]

O'Hanlon, S., & Bertolino, B. (Eds.). (1999). *Evolving possibilities: The selected papers of Bill O'Hanlon*. Bristol, PA: Brunner/Mazel.

O'Hanlon, W. H., & Weiner-Davis, M. (1989). *In search of solutions: A new direction in psychotherapy*. New York: Norton.

BUILDING SOLUTIONS THROUGH LANGUAGE

SOLUTION/COMPETENCY-BASED VOCABULARY

Pathology-Based	Competency-Based
Fix	Empower
Weakness	Strength
Limitation	Possibility
Pathology	Health
Problem	Solution
Insist	Invite
Closed	Open
Shrink	Expand
Defense	Access
Expert	Partner
Control	Nurture
Backward	Forward
Manipulate	Collaborate
Fear	Hope
Cure	Growth
Stuck	Change
Missing	Latent
Resist	Utilize
Past	Future
Hierarchical	Horizontal
Diagnose	Appreciate
Treat	Facilitate
End	Beginning
Judge	Respect
Never	Not yet
Limit	Expand
Defect	Asset
Rule	Exception

Problem Talk	Solution Talk
Hyperactivity	Very energetic at times
Attention Deficit Disorder	Short attention span sometimes
Anger Problem	Gets upset sometimes
Depressed	Sad
Oppositional	Argues a point often
Rebellious	Developing his/her own way
Codependent	People are important to him/her
Disruptive	Often forgets the rules in class
Family problems	Worries about his/her home life
Shy	Takes a little time to know people
Negative peer pressure	People try to influence him/her
Feelings of rejection	People forget to notice/him her
Isolating	Likes being by himself/herself

Therapeutic Collaborations Consultation & Training
Bob Bertolino, Ph.D.
1237 Saddlemaker Drive Saint Charles, Missouri 63304 USA
Phone/Fax 636.300.3885 E-Mail bertolinob@cs.com
Website www.bobbertolino.com

THE LANGUAGE OF POSSIBILITY

⇨ **Dissolving Impossibility Talk**. If clients do not feel heard and understood they will likely close down, become angry, or let therapists know in some way that there is a problem. Still, as we listen and attend to clients, if we only reflect back their experiences many will continue to box themselves into corners by describing situations that seem hopeless, with no way out. What we want to do is add a twist to the idea of pure reflection.

1. Reflect back clients' responses or problem reports in the past tense.

   Client: He's always in trouble.
   Therapist: So he's been in trouble.

2. Take clients' general statements such as "everything," "everybody," "nobody," "always," and "never" and translate them into partial statements. This can be done by using qualifiers related to time (e.g., recently, in the last while, in the past month or so, most of the time, much of the time), intensity (e.g., a bit less, somewhat more), or partiality (e.g., a lot, some, most, many).

   Client: I get in trouble all the time.
   Therapist: So you get in trouble a lot of the time.

3. Translate clients' statements of truth or reality—the way they explain things for themselves—into perceptual statements or subjective realities (e.g., "It seems to you…," "You've gotten the idea…," etc.)

   Client: I'm a bad person because I'm always in trouble.
   Therapist: So you've really gotten the idea that you are bad because you've been in trouble

⇨ **The Moving Walkway.** Another way to begin to open up possibilities for change through language is by using the "moving walkway." By using language as a conveyor belt, we can help clients to create a compelling sense of a future with possibilities before they even take any action.

1. Assume the possibility of clients and associated parties finding solutions by using words such as "yet" and "so far." These words presuppose that even though things feel stuck or unchangeable in the present, sometime in the future things will change. This simple shift in language can help to create a "light at the end of the tunnel."

   Client: I'll never amount to anything.
   Therapist: So far you haven't seen any evidence that you'll change.

2. Recast the problem statement into a statement about the preferred future or goal.

   Client: I'll never get out of the gang.
   Therapist: So you'd like to be able to find a way to get out of the gang?

3. Presuppose that changes and progress toward goals will occur by using words like "when" and "will."

   Client: No one wants to hang out with me because all I do is get into trouble.
   Therapist: So when you start to get friends, how do you think you'll act differently than before?

⇨ **Giving Permission.** While we can control actions, internal experience is another matter. We want to let clients know that whatever they are experiencing is okay, acceptable, and that they can move on. There are two kinds of permission:

1. *Permission to*. "You can."
2. *Permission not to have to*. "You don't have to."

Some clients will feel stuck, thinking that they are bad or terrible for having some experience or thought, or that they shouldn't think or experience it. In these instances, clients will need to be given permission to think or experience whatever is going on with them internally. Perhaps the best way of doing this is to normalize, which provides validation and permission. This can let clients know that they're not bad, crazy, or weird—others have felt similarly. It's important to note that giving permission for internal experience does not mean giving permission for all actions. Here are some ways to give permission to:

Client: I know I shouldn't think about ending the marriage. I just can't help it. I must be a bad person.
Therapist: It's okay to think about ending the marriage and that doesn't make you a bad person.

Other clients will feel that they are being dominated by internal experiences or that they should be having some internal experience that they are not. They might need permission not to have the experience. Here are some ways of giving permission not to have to:

Client: In the support group I attend for parents who've lost their spouses, everyone keeps saying that I need to express my anger because that's a stage of grieving. But I've never felt anger. Is something wrong with me?
Therapist: Each person goes through grief in his or her own way. Some people will experience anger and some won't. It's okay if you don't go through someone else's stages and take your own path to healing.

Although either permission can be given independently, we also have found it useful to give both permissions at the same time. Here are some ways of doing this:

Client: Should I be angry or not? I don't know.
Therapist: You can be angry and you don't have to be angry.

If we only give one type of permission, some clients may feel pressured to experience only one part of the equation or may find the other side emerging in a more compelling or disturbing way. For example, if we only say, "It's okay to remember," the client might say, "But I don't want to remember!" We can counter this bounce-back type response by giving permission to and not to have to, "It's okay to remember and you don't have to remember."

⇨ **Utilization.** We can take what clients bring to counseling, no matter how small, strange, or negative the behavior
or idea seems and use it as a resource to open up the possibilities for change. This is in direct contrast with more traditional approaches that often view such things as symptoms or liabilities. Here are some ways of utilizing client behaviors and ideas as vehicles for change.

Client: My family is extremely dysfunctional and chaotic.
Therapist: So you've had some experience dealing with dysfunction and chaos.

Utilization allows counselors to take behaviors and ideas that are typically seen as deficits, inabilities, symptoms, or negative in general, and turn them into assets. This can be a helpful way of getting clients moving, if they aren't already doing so, in the direction of the change they are seeking.

⇨ **Inclusion.** At times people will feel as if they are in binds and experiencing opposite or contradictory experiences that seem to present conflict. What we want to do is include any parts, objections, feelings, aspects of self, or clients' concerns that might have been left out or seen as barriers to the counseling or goals. As with utilization, we use what the client has brought to counseling. In addition, we include anything that may have

been left out, devalued, or seen as irreconcilable opposites. To do this we use the "and" to link together client experiences. Here are some ways of doing this.

Client: I need to tell you something but I just can't.
Therapist: It's okay to feel like you can't tell me and maybe there is a way you can tell me.

Client: I hate my life. Nothing will ever change for the better.
Therapist: You can hate your life and things can still change for the better.

If clients are feeling stuck, it's often because they are leaving out some part of their experience or don't feel as if they have room for it. The use of inclusion allows counselors to pull together ideas and feelings that seem to be in opposition and may be hindering the change process. This can free clients up to experience all aspects of a situation and move on.

⇨ **Reading Reflections.** Client reflections are a rich source of information as they tell us whether or not we're working in ways that are helpful with clients. To read reflections we must closely attend to clients' verbal and nonverbal communication. Reading reflections can be particularly important at times when clients *appear* to be "resistant," disagreeable, uncooperative, overly quiet, or are tuning us out. We do not interpret such communication as resistance or lack of cooperation; instead, we consider it to be information indicating that what we have been doing as counselors is not working. In many instances it's because we are pushing for change too quickly and are not doing enough acknowledging. Thus, we need to change what we are doing and try to communicate better with clients so that they will feel heard and understood. Here are some ways of reading reflections.

Client: I don't think you're following me.
Counselor: OK. I'll try harder to follow you better. Can you tell me what I said or did to give you the sense that I wasn't following along?

Client: (Silence)

Counselor: It's become a little quiet in here and I'm not sure what that means. So if it's ok with you, I'd just like to check a few possibilities out here based on what I'm understanding from you. (watching closely) I wonder if you're feeling a bit discouraged, or perhaps misunderstood. Maybe you're feeling that I'm moving to quickly here or not quick enough. Or maybe this is just really difficult for you (client nods)—ok, that's fine we can approach this in whatever way feels most comfortable for you.

Counselors' sensitivity to verbal and nonverbal messages can help to alleviate tension and discomfort that clients may be experiencing. It can also help counselors in become clearer regarding the needs of clients, as oftentimes situations that appear bogged-down require closer attention to the reflections being given by clients.

⇨ **Matching Language.** People often speak in verbal patterns. Outcome research indicates that higher ratings of client satisfaction are significantly related to similarity in client-counselor linguistic style. Thus, another way of attending and listening to clients is to match their language by using similar words and phrases, speed, intonation, and patterns. Here are some respectful ways of joining with clients through matching language.

Client: The way I see it, I'm a fool for believing he would change.
Counselor: The vision you've had of yourself is that you've been a fool for believing that he could change for the better.

TAPPING INTO RESILIENCE

Michael Rutter (1987) has defined resilience as "the positive role of individual differences in people's responses to stress and adversity" (p. 316). More specifically, this relates to situations

where a person has lived or grown up in aversive conditions (i.e., poor conditions, underprivileged circumstances, high crime areas) and amongst all that has gone wrong or is wrong, they manage to survive.

With clients we can explore resiliency as something that has contributed to them having some influence over the complaint or problem. To do this we search for resilient *qualities*. This can lead to a shift in how they view themselves. Here are some questions to help practitioners to tap into resilient qualities:

- What qualities do you possess that you seem to be able to tap into in times of trouble?
- What is it about you that seems to come to the forefront when you're facing difficult situations/problems?
- How have you managed, in the midst of all that has happened, to keep going? What does that say about you?
- What are the qualities that you have that enable you to continue to deal with adversity?
- What does that say about the type of person that you are?
- What would others say are the qualities that you have that help you to deal with adversity?

We can also ask questions that help us to explore with clients what *actions* they have been able to take as a result of their inner qualities:

- What have the qualities that possess allowed you to do that you might not have otherwise done?
- How have you used your inner qualities to prevent things from heading downhill any further?
- Tell me about a time when you were able to deal with something that could have stopped you from moving on in life. How were you able to do that?
- What else have you done to keep things from getting worse?
- How has that made a difference with your situation?

References and Resources

Higgins, G. O. (1994). *Resilient adults: Overcoming a cruel past*. San Francisco: Jossey-Bass.

Katz, M. (1997). *On playing a poor hand well: Insights from the lives of those who have overcome childhood risks and adversities*. New York: W.W. Norton.

Rutter, M. (1987). Psychosocial resilience and protective mechanisms. 1987 meeting of the American Orthopsychiatric Association. *American Journal of Orthopsychiatry*, *57*(3), 316-331.

Seligman, M. E. P. (1995). *The optimistic child*. New York: Houghton-Mifflin.Wolin, S. J., & Wolin, S. (1993). *The resilient self: How survivors of troubled families rise above adversity*. New York: Villard Books.

FUTURE PULL: CREATING COMPELLING FUTURES

1. Finding a Vision for the Future

Below is a list of questions that can be helpful with clients in creating a better present and preferred future and assist you in getting clear on their visions and what they want for themselves and perhaps, others around them:

What do you think is important for you to accomplish during your lifetime?
What is your vision of a good future?
What dreams did you or do you have for yourself in upcoming days/weeks/months/years/life?
What are you here on the planet for?
What are teenagers/young people/human beings on the planet for, in your view?
What area do you think you could you make a contribution in?
What would you try to do with your life if you knew that you could not fail?

2. Dealing with and dissolving barriers to the preferred future

Sometimes clients are clear on where they want to go with their lives, but they cannot get there because they perceive insurmountable barriers in their way. They have fears of success or fears of failure. They think they are inadequate to the task of making the dream happen, or they think certain things must happen before they begin to pursue their dreams. Here is a list of questions that might prove helpful in clarifying these perceived barriers:

What, in your view, stops you from getting to where you want to be with your life?
What, in your view, stops you from realizing your dreams or getting to your goals?
What do you believe must happen before you can realize your dreams/future?
What are the actions you haven't taken to make your dreams and visions come true?
What things stand in your way of realizing your dreams and visions?
What would your heroes, models, or people you admire do if they were you in order to make this dream or vision happen?
What are you not doing, feeling, or thinking that they would in this situation?
What are you doing, feeling, or thinking that they wouldn't?

3. Making an Action Plan to Reach the Preferred Future

Having a vision of the future and even realizing what the perceived barriers are will not necessarily take clients to that future. There must be a plan of action and a way to start to take some of those actions to make the future happen. Here are some ideas and questions that can help people to formulate and put into practice actions that will likely create their preferred futures:

What could you do in the near future that would be steps towards getting you to where you want to be?
What could you do in the near future that would be steps towards realizing your visions and dreams?
What would be a first step toward realizing your dream/future?
What would you do as soon as you leave here?
What would you do tonight?
What would you be thinking that would help you take those steps?

With most clients who are stuck in their troubles, just getting them to turn their gaze from the past to the future is a major reorientation. This reorientation can provide information about directions for treatment, meaning and purpose in their life, and lead to the restoration of hope.

UTILIZING THERAPEUTIC METAPHORS

Metaphor includes stories, jokes, puns, anecdotes, riddles, and symbols. Anything that speaks about one thing to refer to another [Gr. *Meta*, to carry and *pherien*, across]

- **Purposes:**

  ➜To introduce new possibilities
  ➜To assess which possibilities appeal most to the client(s)
  ➜To evoke resources (feelings, memories, frames of reference, previous solutions)
  ➜To transfer know-how/resources from one context to another
  ➜To deal with objections
  ➜To channel the discussion
  ➜To join
  ➜To normalize
  ➜To guide associations

- **Elements:**

  ➜ Stories include outline words, which give just enough structure while leaving room for clients to fill in their own details
  ➜ Many words in the story are therefore unspecified as to person, place, time, thing, and action.
  ➜Stories have beginnings, middles, and ends.
  ➜Stories are told in a novelistic way, using enough description to hold people's attention and get listeners involved in the narrative.
  ➜Gestures and nonverbals are used to enhance the story.

* *Adapted from the work of Bill O'Hanlon*

Therapeutic Collaborations Consultation & Training
Bob Bertolino, Ph.D.
1237 Saddlemaker Drive Saint Charles, Missouri 63304 USA
Phone/Fax 636.300.3885 E-Mail bertolinob@cs.com
Website www.bobbertolino.com

REFLECTING, CONSULTING AND CONVERSATIONAL TEAMS

BASIC FORMAT

- The practitioner/job coach/therapist/counselor/social worker/ psychologist/case manager etc., is part of the family system (second order cybernetics)
- The clinician meets with the family for 30-35 minutes
- The team observes during this time
- The family and the team switch places
- The team members talk with one another for approximately 8-12 minutes
- The family and the clinician observe the team during this time
- The family and the team switch once more
- The family is given a few minutes to reflect (3-5 on average)

OPERATIONAL IDEAS

- We base our comments on what actually happens in the room, wondering about and giving personal responses to what happens in the session.
- We situate or ideas in our own experience believing that this invites family members to adapt what we say to fit their personal experience.
- We strive to keep our comments nonevaluative. We wonder about or focus on differences or new occurrences around which family members may choose to perform meaning.
- We have a conversation to develop ideas rather than a competition for the best idea.
- We address ourselves to other team members rather than through the mirror to the family.
- We try to respond to everyone in the family.
- We don't talk behind the mirror, believing that this keeps our conversations fresher and more multifaceted.
- We aim for brevity, especially if there are small children in the family.
- We try not to instruct or lead the family, striving instead to bring forth many perceptions and constructions, so that family members can choose what is interesting or helpful to them.

Resources

Andersen, T. (Ed.). (1991). *The reflecting team: Dialogues and dialogues about the dialogues*. New York: Norton.

Bertolino, B., & O'Hanlon, B. (2002). *Collaborative, competency-based counseling and therapy*. Boston: Allyn & Bacon.

Freedman, J., & Combs, G. (1996). *Narrative therapy: The social construction of preferred realities*. New York: Norton.

TYPES OF QUESTIONS

Therapeutic Collaborations Consultation & Training
Bob Bertolino, Ph.D.
1237 Saddlemaker Drive Saint Charles, Missouri 63304 USA
Phone/Fax 636.300.3885 E-Mail bertolinob@cs.com
Website www.bobbertolino.com

Scaling Questions
Designed to get continual assessment and feedback from people to get them to realize changes or gray areas in the problem situation.

Example: On a scale of one to a hundred, one hundred being no depression and one being the most depressed you could be, where have you been in the past week?

Example: What would it take to get you to have a "seven" week instead of the "six" week you had last week?

Difference Questions
Designed to highlight differences and get the person to compare and contrast things about the problem, exceptions or solutions.

Example: So was that different from the way you have usually handled it?

Example: So his asking questions was different from his typical mode of making accusations?

Accomplishment Questions
Designed to get the person or family to recognize that something positive happened as a result of their efforts.

Example: How did you manage to stop bingeing?

Example: How did you do that?

Goal Questions
Designed to get the person or family to tell you what they are interested in accomplishing or setting the end point for therapy or problem resolution.

Example: How will you know when therapy is successful and we can end?

Example: What will you be doing after therapy? How will others know you've changed?

Compliments/Praise
Designed to give clients credit for their accomplishments, good intentions or level of functioning.

Example: Wow! How did you do that?

Example: Most couples wait until their relationship is on the verge of divorce to seek help. How did you two decide to come in while your relationship was still doing relatively well?

Atypical Experiences in Regard to the Problem (Exceptions)
Designed to elicit descriptions of times when things went differently from the usual problem situation.

Example: Can you recall a time when you thought you would binge, but instead you resisted the urge?

Example: Can you tell me about a time when John was able to sit quietly and surprised you or himself?

Description Questions
Asking people to describe problem or solution situations in observable terms.

Example: How did you know that he was having a better day? What would I have seen on a videotape on that day?

Example: How would I know he was doing something you call passive-aggressive?

Smaller Step Questions/Comments
Designed to get people to scale back their grand ideas about their goals or progress into more achievable ends or progress.

Example: That sounds like a big goal and dream. What kinds of things would be happening in the next week if you were headed in the direction of those big dreams?

Example: What is the first sign you would see that you were doing what you needed to do to get over your depression?

Highlighting Change/New Stories
Designed to get people to notice or acknowledge changes or differences in their perceptions of themselves or other people's views of them.

Example: What do you think your friends would think about you since you have come to think of yourself as able to stand up for yourself?

Example: What effect does knowing that you're resolved not to cut yourself anymore have upon your view of yourself?

Stage of Change Questions
Designed to assess people's stage of change.

Example: What's your part, if any, in what's going on with your family?

Example: On a scale of one to ten, how involved would you say you are with the problem?

Theory of Change Questions
Designed to learn more about clients' theories of problem development, possibilities for change, and potential solutions

Example: What ideas do you have about what has contributed to the problem you're facing?

Example: What ideas do you have about what it will take to solve the problem you're facing?

Therapeutic Collaborations Consultation & Training
Bob Bertolino, Ph.D.
1237 Saddlemaker Drive Saint Charles, Missouri 63304 USA
Phone/Fax 636.300.3885 E-Mail bertolinob@cs.com
Website www.bobbertolino.com

ATTENDING TO AND ALTERING PRACTITIONERS' PATTERNS

Most change occurs early on in treatment. Therefore, if things are not improving or are deteriorating with clients, or if as a practitioner you are stuck, there are several ways that can help in becoming unstuck. A first way is to ask clients questions related to their conversational and relational preferences. Find out what their perceptions are of what is working and what is not. It is not uncommon for clinicians to get stuck in repeating unhelpful patterns that are unnoticeable to them. Here are some questions that can assist with this process:

- How has the way that we've worked toward resolving your concerns been helpful to you?
- What specifically has been helpful?
- How has the way that we've worked toward resolving your concerns been unhelpful you?
- What specifically hasn't been helpful?
- What, if anything, should I do differently?
- What else, if anything, should I do differently?
- What if anything have I not done, that I should be doing?
- What difference might that make for you for me to do that?
- What do you think I've missed about your situation?
- What do you think I've not understood about you or your concerns?

It's important to note that at times practitioners may feel or think that they are working with clients in ways that are completely ineffective or are being unhelpful. In such cases, what we need to remember is that clients often have different perspectives. For example, in an effort to get things going in a better direction, some clinicians will make changes based on "gut feelings." However, therapists' ideas and internal guidance systems about what needs to change may or may not be consistent with clients' views. The best way to determine what is working, what is not, and what needs to change is to ask clients about their perceptions and preferences. When clients provide little or no feedback about conversational and relational preferences or when a therapist remains stuck, a second possibility for attending to and altering therapist patterns is to videotape sessions. Because therapists don't always recognize when they are working in ways that are helpful or unhelpful, taping can reveal aspects of sessions that might not otherwise be remembered. Once a tape has been made, the therapist reviews the tape and considers some of the following questions:

- What did I do well?
- How do I know it was helpful to the client?
- What should I consider doing more of in the next session?
- What should I consider doing differently in the future?
- What changes should I consider making in the next session?
- What difference might that make?

By reviewing a videotaped session the therapist can watch the therapeutic discourse unfold from a different position. This can help to generate new ideas and possibilities for future sessions. Another tack that can be helpful is to get a "second perspective" from another colleague or supervisor.

Source: Bertolino, B., & O'Hanlon, B. (2002). *Collaborative, competency-based counseling and therapy*. Boston: Allyn & Bacon.

P-R-O-D-U-C-T-I-V-E

Prioritize... Make a list each day of things you hope to accomplish. Mark the most important items with a symbol, like a red check mark. If you cannot proceed until receiving information from another person, mark the person's initials next to the item. Throughout the day, a simple glance at the marks you have made to the left of the items will let you know what needs to be acted on next.

Relax... Take care to not overact when things go wrong. Assume that some thing will go wrong, and regard it as another challenge. When estimating the amount of time it will take to do a project, add about 20% for "aggravation time." Remember to take a break when you just can't think anymore.

Open up to new ideas... Taking the time to organize your work area can save a great deal of time later on. Learn a new computer program or attend a seminar. Project yourself into an ideal future to help you decide what additional skills you should develop.

Delegate... Be sure to rely on supportive office help, if it is available to you. These are valuable people who deserve good treatment. Take the time to develop your support staff, and be as clear as possible about what you want. Remember to praise them often. This will save you countless hours later on, and raise the quality of your work.

Uninterrupted time... A large project may never get done if you are constantly interrupted with minor things. Try to set up some time each day for uninterrupted time. Try not to take calls, ask that minor questions be held for later, and close the door, if possible. Sometimes an entire department can earmark a quiet hour. Not one talks to each other, and no calls come in during this hour. Outside of work, too, quiet time is important, so you can reflect on your priorities.

Criticize less… Everyone's work will improve if you can focus more on what you are doing than criticizing the work of others (unless that is your job). When criticism is necessary, try to do it kindly. Others need to continue to be productive too, and kindness keeps the motivation high.

Try not to procrastinate… If you have something you know you should do and keep putting it off, find the best time of day and...just do it! Thinking about it sometimes becomes a way to avoid it. Then action is what is called for. You can always improve on the first draft later.

Identify time wasters... Watch for those nasty details that take hours to work out. If you suspect one coming, stop before you get too far into it and consider whether there are quicker alternatives to solving the problem. Maybe someone else handles this type of thing routinely and could solve the problem in a matter of minutes. This avoids "reinventing the wheel" needlessly.

Variation... To keep yourself from getting bored with your job, try to initiate a little variation. Tasks usually fall into categories of easy, hard, boring, or fun. Varying the order of the tasks will provide a balance in your routine.

Enthusiasm... When you first chose this career path, you doubtlessly felt a lot of enthusiasm for the work. As much as possible, try to recapture this enthusiasm. Compliment others on their work, keeping their enthusiasm alive as well. Feeling good about what you do is the very best guarantee of productivity.

IDENTIFYING, AMPLIFYING, AND EXTENDING CHANGE

- **Clients report new concerns or problems that have arisen between meetings**
- **Clients report that things are better**
- **Clients report that things are so-so**
- **Clients report that things are the same or worse**

- **When change has occurred, amplify those changes and associated solution patterns.**

  - What have you noticed that's changed with your situation?
  - What specifically seems to be going better?
  - When did you first notice that things had changed?
  - How did the change come about?
  - How did you get yourself to do that?
  - What did you do differently?
  - What did you tell yourself?
  - Who first noticed the change? Who else noticed?

- By using the questions outlined above as well as others, changes that have occurred in relation to the problem can be more easily identified. These questions also serve as a way of amplifying any identified change. Furthermore, using exception-oriented questions can be especially helpful in drawing out solution patterns and actions that have contributed to change.
- Many times when change has occurred with a client there's more than meets the eye. That is, there are other ripples or small movements that may be present but are not so clear. To find out about other changes we can ask: "What else have you noticed that's different?" Or, "What else has changed? Again, we also amplify any additional changes that are identified.

- **When change has been identified and amplified, get an idea of how that change is situated in relation to the problem and/or the goals of treatment.** Do clients feel that the change indicates that the problem has been resolved? Have the initial treatment goals been met? We want to know how the change relates to the overall goals of therapy. Consider:

  - Last time you indicated that if you were able to get to work on time on a regular basis you would know that things were better. Now that you've made it work on time for two weeks straight how do you see things?
  - You mentioned last time that if you made it to work on time 18 out of 20 days that would represent an eight. Now that you've done that, what else, if anything, do you feel needs to happen?
  - How does the change that's happened relate to the goals we set in the first/last session?
  - What else, if anything, needs to happen so that you'll be convinced that the problem is no longer a problem?

Attribute Change to Client Qualities

One of the ways that we attribute change to clients is by inquiring about their internal qualities. These questions relate to aspects of "personhood." We consider our root question to be, "Who are you?", and assume that clients' possess positive characteristics that they can tap into when needed. Here some questions that we use to assist with this process and help clients to internalize change:

- Who are you such that you've been able to _____?
- Who are you such that you've been able to stand up to _____?
- Who are you such that you've been able to get the upper hand with _____?
- What does that say about you that you've been able to face up to adversity?
- What kind of person are you that you've been able to overcome _____?
- Where did the wherewithal come from to _____?
- What kinds of inner qualities do you possess that allow you to manage difficulty/adversity?
- What would others say are those qualities that you possess that help you when you need them?

By helping clients to attribute change to internal qualities we contribute to the idea that even though external factors may have had some influence in producing change, it is clients who are in charge of their lives.

Therapeutic Collaborations Consultation & Training
Bob Bertolino, Ph.D.
1237 Saddlemaker Drive Saint Charles, Missouri 63304 USA
Phone/Fax 636.300.3885 E-Mail bertolinob@cs.com
Website www.bobbertolino.com

Use Speculation
When change has happened speculate about what may have contributed to the change from a position of curiosity. The reason for this is it allows the therapist to speak about things without drawing conclusions or trying to establish truths. Speculation in this sense means offering possible interpretations as to what has contributed to the change. One possibility is to speculate as to how the change came about. In doing this it's usually a good idea to speculate about things that are unlikely to be rejected by the person These include, but are not limited to, age, maturity, becoming wiser, and thinking more of other people's feelings. Here how to do this:

Mother: She has done well lately. I really haven't had to get on her about getting up on time and making it school on time.
Therapist: (To daughter): That's great! How have you done that?
Daughter: I just did it. I don't know.
Therapist: That's okay if you're not sure. It may become clearer as you go along. But I have to wonder if part of it is because your getting older and more mature and are making better decisions, or if it's related to you thinking more about your future and how your education might open up door for you. Other people might say that you're just thinking more of others. Who knows?

- Most adolescents will not deny speculation and say, "No, I'm not getting more mature!" It's also helpful to use this type of speculation as an adjunct when people can identify what is different. For example, if a person said, "I knew I better stop so I focused on something else," I might add, "That's great that you were able to focus on something else. I wonder if that's in anyway related to you growing up and getting wiser." It is not necessary that people respond to speculation. If they do the therapist can follow along. If not, just the mere mentioning of something that may have contributed to the change ensures that people will think about it and consider it at least momentarily as a possibility. We are merely highlighting those aspects that may facilitate change and promote an improved sense of self while simultaneously holding people accountable for all their actions.

Move to an Experiential Level
Change is not solely an internal or external phenomenon. It involves a combination of both realms. For some, an invitation to experience change at an internal, experiential level can be significant. Similarly, with some people, when they are able to connect with an experience internally it is more profound. Thus, with clients it can be helpful to move to an experiential level when change is evident. The therapist can ask, "What was that like for you that _____ happened?" Or, "When you were able to _____ how did you feel?"

Share Credit for Change
If change has occurred but clients or others don't seem convinced that it's genuine, it's often because they don't have a sense that they've contributed to the change. Thus in some instances it can be important to share the credit for change with those involved with clients. Here are a few ways of doing this:

- I'm really impressed with how you instilled in your employee the value of _____.
- What part of your supervising do you think contributed most to your supervisee's ability to overcome _____?
- What did you learn from your supervisor about how to overcome _____?

➡ **Anticipate roadblocks, hurdles, and perceived barriers.** It's important to ask people about any concerns that they might have about *potential* future concerns in relation to the problem. We are not implying that there will be a setback, we are merely helping people to orient toward their abilities, strengths, and resources should there be a barrier to staying on track. Here are a couple of questions therapists can ask to inquire about any future areas of concern:

- Can you think of anything that might come up over the next few weeks/months or until we meet again that *might* present a challenge for you in staying on track?
- Is there anything that might happen in the near future that might pose a threat to all the changes you've made?

If people involved identify a potential future concern the therapist can inquire as to how that person might respond differently than they have in past situations. Here's one way of asking about this:

- Let's suppose that down the road you were to face the same or a similar situation that posed difficulty for you in the past. What will you differently? How will that make a difference for you? For others?

POSSIBILITY-ORIENTED BIBLIOGRAPHY

Therapeutic Collaborations Consultation & Training
Bob Bertolino, Ph.D.
1237 Saddlemaker Drive Saint Charles, Missouri 63304 USA
Phone/Fax 636.300.3885 E-Mail bertolinob@cs.com
Website www.bobbertolino.com

Abels, P., & Abels, S. L. (2001). *Understanding narrative therapy: A guidebook for the social worker*. New York: Springer Publishing Company.

Ajmal, Y., & Rees, I. (Eds.). (2001). *Solutions in schools: Creative applications of solution-focused brief thinking with young people and adults.* London: Brief Therapy Press.

Andersen, T. (Ed.). (1991). *The reflecting team: Dialogues and dialogues about the dialogues*. New York: Norton.

Anderson, H. (1997). *Conversation, language, and possibilities: A postmodern approach*. New York: Basic Books.

Bell-Gadsby, C., & Siegenberg, A. L. (1995). *Reclaiming herstory: Ericksonian solution-focused therapy for sexual abuse*. Philadelphia, PA: Brunner/Mazel.

Berg, I. K. (1994). *Family based services: A solution-focused approach*. New York: Norton.

Berg, I. K., & Kelly, S. (2000). *Building solutions in child protective services*. New York: Norton.

Berg, I. K., & Miller, S. D. (1992). *Working with the problem drinker: A solution-focused approach*. New York: Norton.

Berg, I. K., & Reuss, N. H. (1998). *Solutions step by step: A substance abuse treatment manual*. New York: Norton.

Bertolino, B. (1999). *Therapy with troubled teenagers: Rewriting young lives in progress*. New York: Wiley.

Bertolino, B., & O'Hanlon, B. (Eds.). (1998). *Invitation to possibility-land: An intensive teaching seminar with Bill O'Hanlon*. Bristol, PA.: Brunner/Mazel.

Bertolino, B., & O'Hanlon, B. (2002). *Collaborative, competency-based counseling and therapy*. Boston: Allyn & Bacon.

Bertolino, B., & Schultheis, G. (in press). *The therapist's notebook for families: Solution-oriented exercises for working with parents, children, and adolescents*. New York: The Haworth Press.

Bertolino, B., & Thompson, K. (1999). *The residential youth care worker in action: A collaborative, competency-based approach*. New York: The Haworth Press.

Budman, S. H. (Ed.). (1981). *Forms of brief therapy*. New York: Guilford.

Budman, S. H., Hoyt, M. F., & Friedman, S. (Eds.). (1992). *The first session in brief therapy*. New York: Guilford.

Cade, B., & O'Hanlon, W. H. (1993). *A brief guide to brief therapy*. New York: Norton.

Chevalier, A. J. (1995). *On the client's path: A manual for the practice of solution-focused therapy.* Oakland, CA: New Harbinger Publications.

Chevalier, A.J. (1996). *On the counselor's path: A guide to teaching brief solution-focused therapy*. Oakland, CA: New Harbinger.

Christensen, D. N., Todahl, J., & Barrett, W. C. (1999). *Solution-based casework: An introduction to clinical and case management skills in casework practice*. New York: Aldine de Gruyter.

Cooper, J. F. (1995). *A primer of brief psychotherapy*. New York: Norton.

Davis, T. E., & Osborn, C. J. (2000). *The solution-focused school counselor: Shaping professional practice.* Philadelphia, PA: Accelerated Development/Taylor & Francis.

De Jong, P., & Berg, I. K. (1998). *Interviewing for solutions*. Pacific Grove, CA: Brooks/Cole.

de Shazer, S. (1982). *Patterns of brief family therapy: An ecosystemic approach*. New York: Guilford.

de Shazer, S. (1985). *Keys to solution in brief therapy*. New York: Norton.

de Shazer, S. (1988). *Clues: Investigating solutions in brief therapy*. New York: Norton.

de Shazer, S. (1991). *Putting difference to work*. New York: Norton.

de Shazer, S. (1994). *Words were originally magic*. New York: Norton.

Diamond, J. (2000). *Narrative means to sober ends: Treating addiction and its aftermath*. New York: Guilford.

Dolan, Y. M. (1991). *Resolving sexual abuse: Solution-focused therapy and Ericksonian hypnosis for adult survivors.* New York: Norton.

Duncan, B. L., Hubble, M. A., & Miller, S. D. (1997). *Psychotherapy with "impossible" cases: The efficient treatment of therapy veterans*. New York: Norton.

Duncan, B. L., & Miller, S. D. (2000). *The heroic client: Doing client-centered, outcome-informed therapy*. San Francisco: Jossey-Bass.

Duncan, B. L., & Sparks, J. (2001). *Heroic clients, heroic agencies: Partners for change*. Ft. Lauderdale, FL: Nova Southeastern University Press.

Durrant, M. (1993). *Residential treatment: A cooperative, competency-based approach to therapy and program design*. New York: Norton.

Durrant, M. (1995). *Creative strategies for school problems: Solutions for psychologists and teachers*. New York: Norton.

Durrant, M., & White, C. (Eds.). (1990). *Ideas for therapy with sexual abuse*. Adelaide, Australia: Dulwich Centre Publications.

Epston, D. (1989). *Collected papers*. Adelaide, South Australia: Dulwich Centre Publications.

Epston, D., & White, M. (1992). *Experience, contradiction, narrative, and imagination: Selected papers of David Epston and Michael White 1989-1991*. Adelaide, South Australia: Dulwich Centre Publications.

Eron, J. B., & Lund, T. W. (1996). *Narrative solutions in brief therapy*. New York: Guilford.

Freedman, J., & Combs, G. (1996). *Narrative therapy: The social construction of preferred realities*. New York: Norton.

Freeman, J., Epston, D., & Lobovits, D. (1997). *Playful approaches to serious problems: Narrative therapy with children and their families*. New York: Norton.

Therapeutic Collaborations Consultation & Training
Bob Bertolino, Ph.D.
1237 Saddlemaker Drive Saint Charles, Missouri 63304 USA
Phone/Fax 636.300.3885 E-Mail bertolinob@cs.com
Website www.bobbertolino.com

Friedman, S. (Ed.). (1995). *The reflecting team in action: Collaborative practice in family therapy*. New York: Guilford.

Friedman, S. (1997). *Time-effective psychotherapy: Maximizing outcomes in an era of minimized resources*. Needham Heights, MA: Allyn and Bacon.

Friedman, S., & Fanger, M. T. (1991). *Expanding therapeutic possibilities: Getting results in brief therapy.* Lexington, MA: DC Heath.

Furman, B. (1997). *It's never too late to have a happy childhood: From adversity to resilience.* London" Brief Therapy Press.

Furman, B., & Ahola, T. (1992). *Solution talk: Hosting therapeutic conversations*. New York: Norton.

George, E., Iveson, C., & Ratner, H. (1990/1999). *Problem to solution: Brief therapy with individuals and families*. London: Brief Therapy Press.

Gilligan, S., & Price, R. (Eds.). (1993). *Therapeutic conversations*. New York: Norton.

Hawkes, D., Marsh, T. I., & Wilgosh, R. (1998). *Solution-focused therapy: A handbook for health care professionals*. Woburn, MA: Butterworth-Heinemann Medical.

Hoffman, L. (1993). *Exchanging voices: A collaborative approach to family therapy*. London: Karnac.

Hoyt, M. F. (Ed.). (1994). *Constructive therapies*. New York: Guilford.

Hoyt, M. F. (1995). *Brief therapy and managed care: Readings for contemporary practice*. San Francisco: Jossey-Bass.

Hoyt, M. F. (Ed.). (1996). *Constructive therapies 2*. New York: Guilford.

Hoyt, M. F. (Ed.). (1998). *The handbook of constructive therapies*. San Francisco: Jossey-Bass.

Hoyt, M. F. (2000). *Some stories are better than others: Doing what works in brief therapy and managed care*. Philadelphia, PA: Brunner/Mazel.

Hubble, M. A., Miller, S. D., & Duncan, B. L. (Eds.). (1999). *The heart and soul of change: What works in therapy*. Washington, D.C.: American Psychological Association.

Jenkins, A. (1990). *Invitations to responsibility: The therapeutic engagement of men who are violent and abusive.* Adelaide: Dulwich Centre Publications.

Johnson, L. D. (1995). *Psychotherapy in the age of accountability*. New York: Norton.

Kollar, C. A. (1997). *Solution-focused pastoral counseling: An effective short-term approach for getting people back on track*. New York: Zonderman.

Lethem, J. (1995). *Moved to tears, moved to action: Solution-focused brief therapy with women and children*. London: BT Press.

Littrell, J. (1998). *Brief counseling in action*. New York: Norton.

Madsen, W. C. (1999). *Collaborative therapy with multi-stressed families: From old problems to new futures*. New York: Guilford.

Marner, T. (2000). *Letters to children in family therapy: A narrative approach*. Philadelphia, PA: Taylor & Francis.

Matthews, W. J, & Edgette, J. H. (Eds.). (1997). *Current thinking and research in brief therapy: Solutions, strategies, and narratives* (Vol. 1). New York: Brunner/Mazel.

Matthews, W. J, & Edgette, J. H. (Eds.). (1998). *Current thinking and research in brief therapy: Solutions, strategies, and narratives* (Vol. 2). New York: Brunner/Mazel.

Matthews, W. J, & Edgette, J. H. (Eds.). (1999). *Current thinking and research in brief therapy: Solutions, strategies, and narratives* (Vol. 3). New York: Brunner/Mazel.

McFarland, B. (1995). *Brief therapy and eating disorders: A practical guide to solution-focused work with clients*. San Francisco: Jossey-Bass.

McNamee, S., & Gergen, K, J. (Eds.). (1992). *Therapy as social construction: Inquiries in social construction*. Newbury Park, CA: Sage.

McNeilly, R. B. (2000). *Healing the whole person: A solution-focused approach to using empowering language, emotions, and actions in therapy*. New York: Wiley.

Metcalf, L. (1995). *Counseling toward solutions: A practical solution-focused program for working with students, teachers, and parents*. New York: Simon & Schuster.

Metcalf, L. (1997). *Parenting toward solutions: How parents can use skills they already have to raise responsible, loving kids*. New Jersey: Prentice Hall.

Metcalf, L. (1998). *Teaching toward solutions: Step by step strategies for handling academic, behavioral, and family issues in the classroom*. New York: Simon & Schuster.

Metcalf, L. (1998). *Solution-focused group therapy: Ideas for groups in private practice, schools, agencies, and treatment programs*. New York: The Free Press.

Miller, G. (1997). *Becoming miracle workers: Language and meaning in brief therapy*. New York: Aldine de Gruyter.

Miller, S. D., & Berg, I. K. (1995). *The miracle method: A radically new approach to problem drinking*. New York: Norton.

Miller, S. D., Duncan, B. L., & Hubble, M. A. (1997). *Escape from Babel: Toward a unifying language for psychotherapy practice*. New York: Norton.

Miller, S. D., Hubble, M. A., & Duncan, B. L. (Eds.). (1996). *Handbook of solution-focused brief therapy*. San Francisco: Jossey-Bass.

Morgan, A. (2000). *What is narrative therapy: An easy-to-read introduction*. Adelaide, South Australia: Dulwich Centre Publications.

Monk, G., Winslade, J., Crocket, K., & Epston, D. (Eds.). (1997). *Narrative therapy in practice: The archaeology of hope*. San Francisco: Jossey Bass.

Murphy, J. J. (1997). *Solution-focused counseling in middle and high schools*. Alexandria, VA: American Counseling Association.

Murphy, J. J., & Duncan, B. L. (1997). *Brief intervention for school problems: Collaborating for practical solutions*. New York: Guilford.

Nardone, G. (1996). *Brief strategic solution-oriented therapy of phobic and obsessive disorders*. Northvale, NJ: Jason Aronson.

Nylund, D. (2000). *Treating Huckleberry Finn: A new narrative approach to working with kids diagnosed with ADD/ADHD.* San Francisco: Jossey-Bass/Wiley.

O'Callaghan, J. B. (1993). *School-based collaboration with families: Constructing family-school-agency partnerships that work*. San Francisco: Jossey-Bass.

O'Connell, B. (1998). *Solution-focused therapy*. Newbury Park, CA: Sage.

O'Connell, B. (2001). *Solution-focused stress counseling*. Continuum Press.

O'Hanlon, B., & Beadle, S. (1999). *A guide to possibility land: Fifty-one methods for doing brief, respectful therapy*. New York: Norton. [Originally published, 1994, as *A field guide to possibilityland: Possibility therapy methods*. Omaha, NE.: Possibility Press.]

O'Hanlon, B., & Bertolino, B. (1998). *Even from a broken web: Brief, respectful solution-oriented therapy for sexual abuse and trauma*. New York: Wiley. [Hardcover]

O'Hanlon, B., & Bertolino, B. (2002). *Even from a broken web: Brief, respectful solution-oriented therapy for sexual abuse and trauma*. New York: Norton. [Paperback]

O'Hanlon, B., & Wilk, J. (1987). *Shifting contexts: The generation of effective psychotherapy*. New York: Guilford.

O'Hanlon, S., & Bertolino, B. (Eds.). (1999). *Evolving possibilities: The selected papers of Bill O'Hanlon*. Bristol, PA: Brunner/Mazel.

O'Hanlon, W. H., & Martin, M. (1992). *Solution-oriented hypnosis: An Ericksonian approach*. New York: Norton.

O'Hanlon, W. H., & Weiner-Davis, M. (1989). *In search of solutions: A new direction in psychotherapy*. New York: Norton.

Parry, A., & Doan, R. E. (1994). *Story re-visions: Narrative therapy in the postmodern world*. New York: Guilford.

Payne, M. (1999). *Narrative therapy: An introduction for counselors*. Newbury Park, CA: Sage Publications.

Quick, E. K. (1996). *Doing what works in brief therapy: A strategic solution-focused approach*. San Diego, CA: Academic Press.

Rowan, T., & O'Hanlon, B. (1999). *Solution-oriented therapy for chronic and severe mental illness*. New York: Wiley.

Schultheis, G. M. (1998). *Brief therapy homework planner*. New York: Wiley.

Schultheis, G., O'Hanlon, B., & O'Hanlon, S. (1999). *Brief couples therapy homework planner*. New York: Wiley.

Saleeby, D. (Ed.). (2002). *The strengths perspective in social work practice*. Boston: Allyn & Bacon.

Selekman, M. D. (1993). *Pathways to change: Brief therapy solutions with difficult adolescents*. New York: Guilford.

Selekman, M. D. (1997). *Solution-focused therapy with children: Harnessing family strengths for systemic change*. New York: Guilford.

Selekman, M.D. (2002). *Living on the razor's edge: Solution-oriented brief family therapy with self-harming adolescents*. New York: Norton.

Sklare, G. (1997). *Brief counseling that works: A solution-focused approach for school counselors*. Newbury Park: Sage.

Smith, C., & Nylund, D. (Eds.). (1997). *Narrative therapies with children and adolescents*. New York: Guilford.

Talmon, M. (1990). *Single session therapy: Maximizing the effect of the first (and often only) therapeutic encounter*. San Francisco: Jossey-Bass.

Thomas, F. & Cockburn, J. (1998). *Competency Based Counseling: Building on client strengths*. Minneapolis: Fortress Press.

Turnell, A., & Edwards, S. (1999). *Signs of safety: A solution and safety-oriented approach to child protection casework*. New York: Norton.

Walter, J. L., & Peller, J. E. (1992). *Becoming solution-focused in brief therapy*. New York: Brunner/Mazel.

Walter, J. L., & Peller, J. E. (2000). *Recreating brief therapy: Preferences and possibilities*. New York: Norton.

Waters, D. B., & Lawrence, E. C. (1993). *Competence, courage, and change: An approach to family therapy*. New York: Norton.

Webb, W. H. (1999). *Solutioning: Solution-focused interventions for counselors*. Philadelphia, PA: Accelerated Development.

White, M. (1989). *Selected papers*. Adelaide, South Australia: Dulwich Centre Publications.

White, M. (1995). *Re-authoring lives: Interviews and essays*. Adelaide, South Australia: Dulwich Centre Publications.

White, M. (1997). *Narratives of therapists' lives*. Adelaide, South Australia: Dulwich Centre Publications.

White, M., & Epston, D. (1990). *Narrative means to therapeutic ends*. New York: Norton.

Wilgosh, R., Hawkes, D., & Marsh, T. I. (1998). *Solution-focused therapy: Managing human relationships*. Woburn, MA: Butterworth-Heinemann Medical.

Winslade, J., & Monk, G. (1999). *Narrative counseling in schools: Powerful & brief*. Thousand Oaks, California: Sage.

Ziegler, P., & Hiller, T. (2001). *Recreating partnership: A solution-oriented collaborative approach to couples therapy*. New York: Norton.

Zimmerman, J., & Dickerson, V. (1996). *If problems talked: Narrative therapy in action*. New York: Guilford.