



## The Solution-focused Therapy Model: the First Session; Part 1

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This chapter describes and explains the logic of the first session in solution-focused brief therapy, following the above sequence for reasons that will be analysed in the text. Chapter 2 pursues the break and subsequent sessions, followed by discussion of a number of specialist aspects of solution-focused work.

All that is necessary is that the person involved in a troublesome situation does something different. (de Shazer, 1985, p. 7)

For Steve de Shazer, the essence of psychotherapy was that the client is helped to make a change in their situation. Following on his Mental Research Institute training, he realised that any change is likely to be beneficial. The only thing one can be sure of changing is oneself. The first interview in solution-focused therapy is the most important. For many clients this is when the majority of the work is done. Unlike other psychotherapies, the treatment process begins at once. No detailed history is taken.

To join with the client, talking about the problem describes issues prior to the first session, with attention to changes made prior to therapy. Then the focus moves to the here and now, examining goals and exceptions to the problem. The issues are defined using questions about scales from 0–10. The ‘miracle question’ encourages creative thinking and explores possible futures as a means towards developing plans. Structured feedback from the therapist looks at strengths and next steps towards the future, concluding the session. Second and subsequent visits follow a simpler pattern, looking at what has improved since the previous session, further use of scales and discussion of the next steps. The progression from past to future appears to be a useful sequence. This chapter and the next describe the interview process in detail, with examples.

The order presented has been chosen through clinical experience and through teaching accredited courses at St Martin’s College since 1997. After learning the method, practitioners develop their own pattern of use and their own modifications and additions. However, like learning to play a musical instrument, it is necessary to start with basic skills before beginning to improvise. At the same time, the flow of the interview is important. If someone mentions a miracle or a scale or a percentage, then the therapist may choose to move at once to that topic rather than follow the usual sequence. The response to questions about goals or scales may be so detailed and positive that the miracle question is not needed. However, in my experience, asking the miracle question will almost always bring out additional aspects of their best hopes for the future.

### **Assumptions Affecting the Context of Solution-focused Therapy**

The central assumption is that the goals for therapy will be chosen by the client and that the clients themselves have resources which they will use in making changes. Therapists promote descriptions in specific, small, positive steps and in interactional terms. Descriptions favour the presence of solutions rather than the absence of problems; the start of something new rather than stopping something that is happening already. Therapists adopt a respectful, non-blaming and cooperative stance, working towards their clients’ goals from within their clients’ frame of reference.

A detailed history is not essential for solution-focused brief therapy. However, if a story has never been told before, then it may need to be heard before continuing. Safety assessment may require this in any event, if material is being disclosed that has implications for the safety of the client or others. ‘Problem talk’ and speculation about ‘motives’ or ‘purposes’ of symptoms are avoided.

It is preferable that any prior assumptions about hidden motives and unconscious mechanisms on the part of the therapist do not interfere with attention to the content of the client's discourse. In de Shazer's words (1994), the interview is 'text-focused'; that is, the information comes from the material offered by the client and it is their understanding and language employed. The alternative, applied in traditional therapies, is a 'reader focus', in which the reader/therapist has special knowledge and only needs enough from the client to make a fit with the preconceived ideas and plans of the therapist. This concept of therapy as text-focused links well with Wittgenstein's (1965) view of language as the essential tool for thought. The client has the text, and ideas in the mind of the therapist should not intrude on this material. The lack of technical language in solution-focused brief therapy is both a consequence of this view of therapy and an asset in communicating with clients.

Steve de Shazer carried this idea further to look at the effect of literally using some of the client's words or turns of phrase in every response that is made. This is an amazingly effective technique for building relationships with clients quickly. It is equally useful in other conversations with clients. This skill is conveniently referred to as 'language matching' and represents a way of staying connected to the client and their experience of their situation. Language matching ensures that the therapist is not only paying attention to the client's every word but that this is clearly recognised by the client. Ideally, the therapist will use words from their last response in each comment or question. If the response is monosyllabic or 'Don't know', then a word from an earlier reply can be used. The skill for the therapist lies in being able to ask the necessary questions while using something from their response to do this.

Psychodynamic therapists say that if an emotion is named in a session, then that emotion will soon appear, often accompanied by memories and experiences connected to it. This is comparable to the Stanislavsky method used by actors in portraying emotions. Therefore it is unwise to introduce topics or emotions into the session unless the client has done so first. Dr Plamen Panayotov from Bulgaria has suggested that the sequence is thinking, then sharing, discussing and acting. So in our team we always ask 'What do you think about that?', not 'What do you feel about that?', because an answer about feeling will be less precise, less behavioural and less open to change by direct means. Feelings can be modified by hypnosis, eye movement desensitisation and reprocessing (EMDR) and by medications (including street drugs). All of these methods require some dependence on the therapist or on the suppliers of medication. Otherwise changes to feelings occur via cognitive or behavioural events.

A number of physiological and psychological studies have shown the influence of words on our functioning and behaviour. Hausdorff et al.

(1999) have shown that elderly people exposed to positive comments about aging showed fewer disturbances of gait thereafter than those exposed to negative comments. Bargh et al. (1996) showed that talking to older people about difficulties of later life reduced gait speed in the experimental group. In a detailed study, Rosenkranz et al. (2005) showed that when asthmatics heard asthma-related words such as 'wheeze', then their brain and lung functions changed towards patterns associated with illness. Van Baaren et al. (2003) found that a waitress who repeats the customer's order receives larger tips than one who does not. Seligman (2002) has developed Positive Psychology, whose whole premise is that using positive words and resources leads to more effective personal and emotional functioning.

## The Structure of the First Session

When arranging the session it can be useful to tell your clients that family or friends can come to the appointment if it will be helpful. It is most productive to work with those who want to make changes or who can provide resources. In this, solution-focused therapy differs from family therapy because in most family therapy it is customary to see all family members even if they are disruptive or do not want to make changes.

It is also useful to ask clients to note what changes they make prior to the first session. To do so implies that change is inevitable and that clients will themselves be active in promoting changes.

## Introduction

### Introduction: Key Questions

Introduce yourself.  
What do you like to be called?  
What do you want to get out of being here today?

From this point on use the client's words and language whenever possible. The Mental Research Institute workers who constructed strategic therapy (Watzlawick et al., 1974) noticed that using the name given by the client to their problem was much more powerful than applying a professional title to it. Applying a new title usually gives the client the impression that they are being contradicted. It devalues their knowledge of the situation. Expert 'jargon' is best avoided unless it is introduced for a specific purpose.

Language in this sense includes non-verbal behaviour. In everyday speech 55 per cent of the information is relayed in non-verbal cues, such as dress and posture, 38 per cent is vocal, such as tone of voice and volume, and 7 per cent forms the linguistic content (Mehrabian 1981). Also, language is itself a behaviour, so that a behavioural description may consist of reported conversations. If someone uses language to describe themselves doing something, then that behaviour is more likely to become part of their repertoire. So if someone says 'I could do that' then it becomes more likely that it will be done. This is a common element in all therapies that include talking about change.

Many therapists like to paraphrase or recapitulate the client's account, but the client could experience this as a contradiction. Therefore it is important to do this respectfully, making it clear that it is intended as a clarification that you are understanding the client correctly.

## Problem

Information gained at this stage will also be useful in conversation about goals and exceptions (below). Having a baseline account of the problem makes it easier to assess progress later. Repetitive accounts of the problem are common, perhaps because people believe that therapy requires this. One of the bases of Freud's free-association technique (1895) was his belief that given enough opportunity to talk about the problem, clients would eventually exhaust their descriptive powers and would have to reveal new material. Having attended to the description of the problem at the start, it is easier to interrupt or redirect the conversation later if the client restarts talking about the problem.

A period of problem-free talk (George et al., 1999) is often a good beginning, especially if clients appear unsure of what they want from the session at the start. A few minutes' talk about something they enjoy or a skill that they possess allows them time to think about what they want. Another option is to collect factual information about what they do, where they live and what family they have at home or nearby. This is usually neutral or problem-free and provides valuable information about their social context and abilities. Similarly, if the session seems to be moving too fast for a client, a brief talk about a skill or pleasure helps to slow the pace appropriately. The questions below about exceptions often produce topics that can be developed in this way.

If more than one person is present, it is important to ask them whether they agree with the description of the problem and of any changes that have occurred. This will generate useful information and helps to encourage others in contributing to solutions.

### Problem: Key Questions

How often does ... happen? (days/parts of days)  
 How long has it been going on?  
 Has it ever happened before?  
 How did you deal with it then?

#### It is important to get a practical description in behavioural terms:

What is said/done?  
 Who says it/does it?  
 Who notices?  
 What happens next? And then what?  
 What else?

**If the description is unclear you may ask 'If you made a video of ... happening what would I see on the tape?' or 'If I was a fly on the wall what would I see happening?'**

*Therapist:* What do you want to get out of being here today?

*Client:* Don't know. I suppose I just want you to help me stop all this drinking.

*Therapist:* How many days in the week does the drinking occur?

*Client:* Every day.

*Therapist:* Do you drink the same every day?

*Client:* Yes; four or five pints of lager both at lunchtime and teatime as well as wine in the evening plus spirits at weekends.

*Therapist:* Lager and wine ... What happens when you drink that much?

*Client:* I go on drinking until I pass out.

*Therapist:* When did you start drinking until you pass out?

*Client:* I'd say it's been this heavy for about two years.

*Therapist:* Two years ... Who else notices that you are drinking so heavily?

*Client:* My mum ... I hit her last week when she told me off about drinking.

*Therapist:* Who else notices as well as your mum?

*Client:* Other family told me to get myself sorted out after I had hit my mum.

Clients sometimes say that there are many problems or that they do not know where to start. However, in the context of brief therapy, it is important to work with only one problem at a time. If the focus shifts back and forth between different problems it can be difficult for the client and therapist to make progress. The following example shows how this sort of response from the client can be handled:

*Therapist:* Mostly we can only work with one problem at a time. Which is the biggest issue for you at present?

*Client:* The drinking worries me most but it comes from the depression.

*Therapist:* We can move on to other problems if necessary, after the drinking.

In practice it is rare to need to take up a second problem. Solving one large problem releases enough energy for clients to deal with the other issues themselves. This does not exclude the situation in which clients 'try you out' with a minor problem and then reveal a more major concern later. In that case it is necessary to clarify with them which is the problem that they want to work on first.

In solution-focused work Steve de Shazer said on many occasions that the word 'Why' should be avoided. 'Why' leads to speculative and general answers that do not usually clarify goals or behaviour. If more details are needed as to the process that leads to an outcome, which is usually what we mean when we ask 'Why', then 'How come ...?' is a good alternative, since it is more likely to lead to a behavioural description.

If you hear the word 'should' from a client, listen carefully. In English 'should' has two meanings. The concrete meaning is shown in statements such as 'The Finance Department should send your pay cheque.' This states that it is the correct responsibility of the Finance Department to carry out this action. The other, less concrete, meaning of 'should' is 'This action ought to be carried out'. This usually refers to an emotional action, which cannot or will not be controlled by the client. This meaning comes into play in 'I should forgive him ...' or 'I should stop worrying'. This may stand for 'I have been told that I should ...'. Thus it can be useful to ask 'Who says that you should ...?' Often this refers to one specific influential person in their past or present life. This person's opinion may be inappropriate or unhelpful in the present situation. Similarly, if there are remarks such as 'People think ...' or 'Everybody knows ...' it is useful to ask 'Who in your life says this/thinks this/knows this?' Again, it is usually one influential person. Sometimes engaging that person in the therapy can be helpful, or asking what this person will think about the miracle and other changes later in the session.

Rarely someone will present with a story of a problem that has never been told before. If this does occur, the issue is often sexual abuse in childhood or some other major family secret. In such a case it may be necessary to listen to the story before moving on to solution-focused work. Chapter 8 includes discussion of ways to manage these issues.

However, disclosure often is not needed for therapy to progress; it depends on the goals of the client. It can sometimes be useful to ask 'Suppose you pretend that you have told me already; how will things be different for you?' If a client insists on repeating a lengthy story, it can keep the narrative moving to say 'What happened next?' at every pause. This shows that the therapist is taking a constant interest, reduces talk about extraneous details and keeps the narrative moving forward.

## Pre-session Changes

Addressing a problem does not begin with seeing a therapist. Most people have tried other ideas first. Coming to see a clinician is usually a result of

attempts to solve the problem, not the first step taken in problem solving. In Salamanca, Beyebach et al. (1996) have found that those clients who see themselves as able to influence events have often made pre-session changes and that this predicts a good outcome for their therapy (see Chapter 6).

### Pre-session Changes: Key Questions

Have there been changes for better or worse since you decided to take action?  
Who else noticed this?

Some clients will criticise previous treatments or therapists when asked about pre-session changes. This lets the therapist know what suggestions are likely to be refused when the time comes for feedback. If another clinician is criticised, a useful response is to say 'I have always heard people speak well of X until now.' This demonstrates respect for their opinion but signals that the therapist will not be drawn into any scapegoating or collusion.

*Therapist:* What changes have happened since you decided to stop drinking?

*Client:* I've actually cut down a bit already so I have managed to get four college assignments in, which was a relief.

*Therapist:* What else has happened as well as finishing your assignments?

*Client:* I'm also taking driving lessons and spending more time with some friends who don't drink, or at least who do not drink much. They are good friends for me!

### Goals

Seek specific practical descriptions of goals. Check for reality, for example 'Will you *really* never argue again?' If the therapy is failing to make progress or if a client's actions do not seem to make sense, it is important to confirm what the goals are, or to ask: 'Your goal when you came here was to ...; How does this help you towards that?' For Mental Health Institute strategic therapists, a client with vague or poorly formed goals required careful thought because the interview method required specific information. With solution-focused work, a specific goal is less important because 'What will be different?', 'What will you be doing instead?' can often be clearly described even if the goal itself cannot be defined. The goals often relate to the problem and therefore may not be essential to the solution.

All the questions are framed using the future tense 'What will you be doing when ...?' and not the future conditional 'What would you be doing



when ...?' It is helpful to maintain this use of tenses throughout the interview whenever possible. It creates a constant assumption in the therapist and the client that something is definitely going to happen, not merely that a possibility exists that it might happen. This draws on the Ericksonian concept of pseudo-orientation in time, in which stories of a successful future are collaboratively constructed (de Shazer, 1988). The conversation makes this successful future easier to recognise and to achieve.

The question 'What else?' is invaluable. It implies that you are following the story closely and that you know that there is more to come. It is surprising how often clients will react to this simple query by producing more information and ideas. To avoid being repetitious, you can extend the question by adding it to their last response: 'As well as X, what else is happening then?'; 'As well as X, what else helps?' Linguistically, 'What else?' implies a continuous dialogue, so it helps to maintain the relationship with the client even if the therapist is not yet clear about the situation. The same phrase can be useful in dealing with distressed clients where little information has been forthcoming. Once new information stops or if time is precious, to ask 'Anything else?' will imply that this element of the discussion is coming to an end.

Another useful word is 'instead'. Any statement containing a negative can be reversed easily to 'So what will you be doing instead of X?' This one change can make an enormous difference to the information offered and to the atmosphere of the session.

### Goals: Key Questions

What will it be like when the problem is solved?  
 What will you be doing instead?  
 When that happens, what difference will it make?  
 How will other people know that things are better?  
 Who will notice first? And then who?  
 What else will be different?  
 What else?  
 What else?

**It is important to ask what they will be doing, not what will have stopped.**

*Therapist:* So when things are better will you be doing these things?

*Client:* Yes, and I won't be drinking so much.

*Therapist:* So you will be drinking less?

*Client:* Yes.

*Therapist:* What else will be better when you are drinking less?

- Client:* I will be spending more time doing things with my old friends from school and getting my work in on time for college. I won't feel so tired and fed up.
- Therapist:* How will you feel instead of being tired and fed up?
- Client:* Ready to take on anything!

To retain the focus on solutions it is important to break into or interrupt the client's 'problem talk'. Although this may feel uncomfortable at first, it is possible to show the client that you are still connected with their concerns by using language matching and talking about what they want to achieve in therapy.

- Client:* Talking about goals is no use while drinking is the problem. I've been drinking for years and I've ...
- Therapist:* You have told me about the years of drinking just now. This has been a problem for a long time and I want to understand it properly. It will help me to understand if I know what you want to achieve.

Many responses in conversation can be summarised as 'yes', 'no' or 'maybe'. As soon as it is clear which one it is, the next question can be asked. As long as this is done respectfully and with language matching, it appears to be acceptable to clients. This can save time in sessions, as can not asking clients to dwell on painful topics unnecessarily.

## Exceptions

Asking about exceptions is particularly useful with goals that are normally viewed as resistant to change, such as alcohol and drug misuse or domestic violence. Clients may be feeling quite hopeless about their ability to change or control their situation. They are surprised to find that there are small exceptions where they clearly control or delay behaviours. This improves their sense of self-mastery and their ability to plan further small steps.

### Exceptions: Key Questions

- What about times when the problem is not happening?  
Or when it is less?
- You mentioned earlier that some days/times are better. What is it like at these times?
- What are you doing instead at these times?
- What else is better at these times?

Who notices first when things are better for you?  
 And then who?  
 What do they notice at these times?  
 What else?

**Again, as with goals, it is important to get descriptions of what they are doing, not of what they are not doing.**

*Therapist:* Tell me about the other times when things are going better?

*Client:* I'm getting on better at home with everyone, especially Mum. I am enjoying college more and feeling a bit healthier in general.

*Therapist:* What else is different at college?

*Client:* I spend more time talking to people that I know when I don't have hangovers.

*Therapist:* Who else notices when you have no hangovers and are talking?

*Client:* My friends notice, and my family when I go home.

The following questions come from systemic family therapy rather than solution-focused therapy. However, the responses are often useful.

- Who is the boss in your family?
- How are decisions made?
- Who makes which decisions?

Power issues are a reality of human affairs and these questions highlight them at the relevant level. Asking the questions causes these issues to be thought about, sometimes for the first time. The replies may not be verbal. For example, if everyone looks at the mother before saying 'There is no specific boss', then it is likely that the mother is the key decision-maker. For most families the important thing is that someone makes decisions that the rest can follow. A complete lack of effective decision making is usually not comfortable for any family or any group of people. If the boss in the family wants change to occur, it is much more likely to happen. If the boss of the family is alcoholic or an adolescent behaving in undesired ways, then it may be useful for others to recognise this. In one case, devoted new parents allowed their toddler to decide when it was teatime and bedtime, with the result that they might still be awake at midnight or not eat in the evenings. Once they recognised that this was a source of difficulty they decided to restrict him to being in charge of a more limited range of activities, with beneficial results for all concerned.

## Scaling

Scaling questions are one of the great assets of the solution-focused therapist. They help the client to move from all-or-nothing goals towards less

daunting steps. The scale has no reality outside the negotiation with the therapist but is an instantly usable means of tracking progress. Scales also increase clarity of communication with other professionals who may be involved with the client.

Scaling can also be used in other ways. For example, 'How confident are you of reaching the number you have chosen as a goal?' People who have come to therapy only as a last resort may be able to identify goals but initially have no confidence that they can reach them. In relationship problems it is useful to ask 'On a scale of 0–10, how confident are you that you will be together in two years' time?' Clients often learn from their own replies, whether the partner is present or not. If both are present, then the same question can be effective. If one says '2' and the other says '10', then they have learned something about how they are communicating with each other. It is not always necessary for the therapist to comment on this directly.

### Scaling: Key Questions

Please think of a scale from 0–10 with 10 being the best. Nought is how you felt when things were at their worst. Ten is as good as things can be in relation to this problem.

Where are you now on that scale right now? *[pause]* Give it a number, for example 2 or 3.

If not precise, 'nearer 2 or nearer 3'?

How long will it take to get to 10? *[prompt if necessary to get a time – 5 years? More? Less?]*

Maybe 10 is too big a goal?

Is something lower more realistic?

What number will be acceptable for you?

How will you recognise when you are one point further up the scale?

What else will be different when you are one point further up?

Who will notice?

How long will it take to get one point up the scale?

Clients sometimes need some prompts to answer 'How long ...?' If you offer 'Maybe a year? Or longer?' they will often respond that they expect change to be sooner. You can then propose a shorter time. Clients' estimates of the time required are often wrong but the process demonstrates to clients that they have more predictions about the situation than they knew. It also shows the therapist what pace they like to use for making changes. If someone wants instant results, then in the feedback it can be suggested that this may be unlikely if the problem has been developing

over a long time. If a person expects change to be very slow, then a longer gap between sessions may be appropriate. It is a good rule that the therapist should not be working harder than the client, or trying to go faster than the client can accept. The phrase 'solution forced' has been used to describe this phenomenon (Nylund and Corsiglia, 1994). Use 'will' not 'would' in questions whenever possible, as this increases the predictive effect of planning the future.

- Therapist:* Where is the problem today on a scale where 0 equals the worst and 10 equals the best that you hope for?
- Client:* I'd say maybe 4 or 5.
- Therapist:* Nearer to 4 or nearer to 5?
- Client:* 5.
- Therapist:* What will need to happen or change for you to go up half a point on the scale?
- Client:* Sort things out with my bad drinking 'friends'.
- Therapist:* How will you sort things out with them?
- Client:* I'll tell them that I need to concentrate more on my college work.
- Therapist:* As well as you concentrating, how will other people recognise when you are one point up on the scale?
- Client:* They will see me happier, more in control of everything and that I'm noticeably drinking less. I'll be less short-tempered and rude to people, especially mum. I will just be nicer in general to be around!

Ask others present if they agree with the answers given. It can be useful to ask them if the client's number on the scale was what they expected.

It is sometimes suggested that solution-focused brief therapy ignores feelings. However, in practice it is very common for the first response to 'How will you recognise when you are one point further up the scale?' to take the form 'I will feel ...' Acknowledging this feeling, it can then be expanded into the behaviours that go with this feeling and the reactions of others to these changes: 'When you feel ..., what else will be different?'

'On a scale of 0–10, how committed are you to achieving what you want?' Answers to this question are often helpful in identifying strengths and resources, especially if clients are feeling pessimistic.

- Therapist:* You say you are at 5 on the scale today. If we think about a different scale from 0–10, how committed are you to controlling your drinking? Give it a number?
- Client:* How committed ... you mean how determined am I to sort it? I guess 8 or 9 out of 10; I don't want to be in this trouble in a few months' time.
- Therapist:* What will help you to be out of trouble, since you are 8 out of 10 determined to sort it?
- Client:* I have fixed things in my life before, and my mum and friends will help.

Steve de Shazer (2005) points out that goals are associated with the problem, while scaling and the miracle question are future-oriented and associated with solutions.

## The Miracle Question

The miracle question is a common tool used by solution-focused therapists. Clients appear to experience pleasant emotions during their replies, which enhances their experience of therapy and is in itself another exception to their previous state. Creative thinking is stimulated. It is common for clients to start haltingly but suddenly come up with some completely new goal or ambition.

### Miracle Question

I'm going to ask you a kind of strange question now.

Suppose [pause]

you go to bed and to sleep tonight as usual [pause]

and while you are asleep a miracle happens [pause]

and the problem that brought you here today [look round all present] is solved [pause].

But you are asleep and don't know that it has been solved [pause].

What will be the first small signs that this miracle has happened and that the problem is solved?

The work of Bandler and Grinder, the founders of Neuro-Linguistic Programming (1979), emphasises eye movements as an indicator of internal processes. Specifically, they state that for the majority of people with normal neurological organisation, envisaging new material involves a fleeting movement of the eyes upwards and to the right or that their eyes will unfocus briefly. It is a common experience when watching clients respond to the miracle question that this will happen. Either of these events are promising signs, suggesting that some useful response to the miracle question will be forthcoming. This applies even though Bandler and Grinder say that 50 per cent of persons are visually oriented, 30 per cent favour auditory information and 20 per cent favour kinaesthetic/somatic information. Nevertheless, such an eye movement is common to the majority of clients, not just 50 per cent. It may be that the miracle is a visual experience initially.

Common first responses are a silence or an 'I don't know'. This appears to be about a delay for thought as it is often followed by more detailed replies. Harry Korman, of Sweden, has identified from studying videos of therapist behaviour that it is important for the therapist not to move or speak for a short period during this first response. He suggests that if you move or make a sound, this implies that it is now your turn to speak, which will stop comment from the client. Steve de Shazer endorsed this finding; he suggested that a pause of six to ten beats is long enough. Bryson (1990) quotes linguistic studies which show that for the English language, four seconds is the longest silence that can be tolerated in normal conversation. If there is still no comment then the questions below can be used to prompt for information.

- Will you know at once that the miracle has happened? How will you know?
- What will happen next?
- Who else will notice?
- How will they tell?
- And who next?
- What happens next?

If necessary this can be expanded by enquiry about changes to breakfast, clothes, work and interests. Previously described goals and exceptions will provide ideas for this. Others present can be asked to comment about what the miracle will be like.

Small children may prefer 'If you could wave a magic wand' or 'Suppose magic happens and ...'.

Some followers of Islam may consider it presumptuous for humans to talk of miracles, which they believe to be the province of God. Some traditions of Buddhism will reject the miracle formula because the Buddha forbade miracles to his followers. Interestingly, he did so on the grounds that miracles were frequent and ought not to be used as a means of convincing people about any particular religious truth.

If the 'miracle' formula is not acceptable you can use 'When you meet us in five years and the problem is solved, what will you tell us is happening?', or 'When you send us a video of what you are doing in five years' time, what will we see on the video?', or Erickson's technique (de Shazer, 1985): 'If we could look into a crystal ball and see the future, what will we see?'

*Therapist:* I'd like to ask you a strange question: suppose you go to bed tonight as usual, and while you are asleep a miracle happens, and the problem that brought you here today is solved. But you are asleep and do not know that the miracle has happened; what will be the first small signs when you wake up in the morning that the miracle has happened and that the problem is solved?

- Client:* I don't know. No hangover? And ... I'd feel happier. I would not drink in the afternoon.
- Therapist:* Who will notice that this miracle has happened?
- Client:* Everyone! Especially mum!
- Therapist:* How will you know that mum has noticed?
- Client:* She will tell me and she will smile at me instead of nagging.

Ferdinand Wolf and his colleagues in Vienna examined the use of 'will' as against 'would' in the responses to the miracle question. They found that the use of either tense by clients did not predict overall outcome or the likelihood that specific elements of the miracle would be achieved. They did not examine the use of these tenses by the therapist. They found that any response linked to the miracle question did predict a good outcome (de Shazer, 2005).

With some clients who have experienced a recent loss or bereavement, their miracle will be a restoration of the loss, such as 'My girlfriend will come back', 'My gran will not be dead'. This is evidence that they are still in the 'numbness' stage of bereavement and have not yet accepted their loss. Asking the miracle question is a quick way to determine if this is their situation. They will not be able to develop new visions of the future until they accept the loss, so further miracle details are unlikely to be useful at this stage. Possible responses are: 'Is there any chance that you will get together with your girlfriend again?' or 'It would be good if your grandmother could come back to life but I guess that this is not very likely to happen?' The focus then is on crisis intervention questions as below. Other useful questions can be found in the discussion of self-harm in Chapter 2.

### Surviving the Present: Key Questions

- How will you get through the rest of today?
- How have you kept going so far?
- What else helps?
- Is there anyone else who shares this with you?
- What were the happiest times with X?
- Can you do any of the same things without X?
- What can you do keep their memory alive?
- What would X want for you now?
- What is happening now that you want to go on happening?

Sharry's (2002) scale from 1–10 can be useful: 'How confident are you that you can get through the day/the weekend? What would increase that by one point?' He also uses the interview to take stock of the effect of the event



itself: 'Has this event made you stronger or weaker? Are there things that you are thinking now that had not occurred to you before? Is it possible that some good might come of this? If you look back in six months and see that this turned out for the best, what will you be doing then?'

The concept of 'resistance', found in many schools of therapy, assumes that if therapy is not making progress, then clients are failing to cooperate for conscious or unconscious reasons of their own. This largely absolves the therapist of responsibility and implicitly or explicitly blames the client. In an early paper on 'The death of resistance', Steve de Shazer (1984) criticised this position. He maintained that there is no such thing as resistance, only the client's unique way of cooperating. It is part of the therapist's task to seek ways to engage with the client successfully. If the client did not do a task, then the fault is with the task and its timing or presentation, not with the client. The Mental Research Institute also held this view of resistance versus cooperation.

Walter and Peller (1992) make the point that 'The meaning of the message is the response you receive (p. 26). In solution-focused work the question may appear clear to the therapist, but the interactional/socially constructed meaning is only apparent when the response comes from the client. This is contrary to the idea that it is the client's 'fault' for misinterpreting or resisting the meaning of a question. It is the task of the therapist to take the responsibility for clear communication. Equally, it is the task of the therapist to recognise and use the response that is given. If the response is unexpected, then it provides clues about the therapist's clarity in regard to this particular client and about the issues that are important to this particular client.

In the same vein it is important not to work harder than the client. The flow of the interview is important. Being 'solution-forced', jumping in with compliments prematurely or demanding answers to the standard questions, is not appropriate. This process is analysed by Nylund and Corsiglia (1994). They see it as a novice error, often linked to excessive enthusiasm and to heavy caseloads. They emphasise the importance of pace and timing in solution-focused interviews. In recent years Steve de Shazer (2005) said that if he had to lose one solution-focused question, he would rather lose the miracle question and keep the scaling questions. He suggested that it is easy to maintain the flow of the interview using scaling questions.

## Conclusion

This completes the initial part of a first interview. The client has described the problem, identified goals and exceptions to the problem and used scaling questions as a means to measure change and to identify small steps

forward. The miracle question has enlarged on this process and may have generated new possibilities. At this point many therapists will take a break for reflection, and this option will be explored in the next chapter.

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### Key Points

- Language matching is a major strength of solution-focused therapy.
  - The sequence of questions may vary once the therapist feels confident about this.
  - Maintaining the flow of the interview is important.
  - Concrete and behavioural descriptions of events clarify the situation and make it appear more manageable.
  - Talking about the problem is a means of joining with the client.
  - Pre-session changes are important building blocks for progress.
  - Goals are central to monitoring progress.
  - Exceptions are common but often go unnoticed.
  - Scales can be used in many different ways.
  - The miracle question encourages creative thinking and some surprising changes follow its use.
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