Solution-Building Conversations: Co-Constructing a Sense of Competence with Clients

Insoo Kim Berg & Peter De Jong

ABSTRACT: The authors examine the social constructionist nature of solution-focused therapy. The therapy's components are illustrated through the presentation of a first-session conversation between Insoo Kim Berg as therapist and a 19-year-old mother, who states that she is "stressed out and depressed." As the conversation develops, the young mother's sense of herself changes and the integration of the therapy's components become apparent. Next, existing outcome research is reviewed. Although descriptive in nature and limited in scope, research suggests positive outcomes for diverse clients and presenting problems. Finally, several connections are made between solution-focused procedures and social constructionist theory: the social construction of reality, language as the medium and substance of meaning, client change through the construction of new meanings, the client as expert, taking a collaborative stance, reflectivity, drawing on client strengths, and solutions as co-constructions.

Human beings, for the most part, will go to great lengths to understand the significance or meaning of their experiences. If an experience is important to a person, he or she reflects on it, puts impressions into words, and converses about it with others. The desire to find and communicate the most obvious and unique of all human characteristics (Mead, 1934).

The theoretical perspective of social constructionism—as it relates to the above observation about human beings—maintains that people develop their sense of what is real through conversation with and observation of others (Berger & Luckman, 1966; Garfinkel, 1967; Geertz, 1973; Gergen, 1985; Watzlawick, 1984). It also holds that as people interact with and observe one another, their perceptions and definitions of what is real frequently shift, sometimes dramatically.

Therapeutic approaches generally regarded to be consistent with a social-constructionist view attempt to foster client change by opening up new views of reality. The client's "problem," Hoffman (1985) states, "is the meaning system created by the distress" (p. 387). Change occurs through the client and therapist creating new meanings that relieve the distress and allow the client to lead a more satisfying and productive life.

A social-constructionist approach can be taken with clients in several ways (see Andersen, 1987; Anderson & Goolishian, 1992; de Shazer, 1991; Tomm, 1987; White & Epston, 1990). In this article, we present the solution-focused approach by summarizing its main assumptions and components, illustrating its interviewing procedures with a case example, demonstrating how ongoing measurements of client progress are integrated into solution-focused conversations, indicating how the effect—

Insoo Kim Berg is Director, Brief Family Therapy Center, Milwaukee, Wisconsin, and Peter De Jong is Director of Social Work, Calvin College, Grand Rapids, Michigan.
tiveness of the approach is beginning to be researched, and suggesting various links between solution-focused procedures and social constructionism.

Solution-Focused Basics

Solution-focused therapy was pioneered through the work of de Shazer (1985, 1988, 1991, 1994), Berg (1994), Berg and Miller (1992), and their colleagues (de Shazer et al., 1986) at the Brief Family Therapy Center in Milwaukee, Wisconsin. Its assumptions, structure, and procedures were developed inductively during approximately 20 years of disciplined observation of sessions with clients. Similar to Rappaport (1981), de Shazer and his colleagues (1986) concluded that solutions for clients are not scientific puzzles (such as unraveling the meaning of DNA codes) to be solved by practitioners, but rather changes in perceptions, patterns of interacting and living, and meanings that are constructed within the client's frame of reference. In addition, de Shazer and colleagues (1986) assume that clients are competent at conceptualizing an alternative, more satisfying future and at figuring out which of their strengths and resources they can draw on to produce the changes they desire.

The practitioner's role in the solution-focused process is continually to invite clients to explore and define two matters: (1) what it is they want different in their lives (goals) and (2) what strengths and resources they can bring to bear on making these desired differences a reality. The practitioner affirms and amplifies client definitions of goals, past successes, strengths, and resources as they emerge through conversation. Consequently, these conversations focus more on building solutions than on solving problems.

De Jong and Berg (in press) state that "building solutions" involves a different set of stages from those used in problem solving. The well-known stages of problem solving (excluding the relationship-focused stages of engagement and termination) include definition of the problem, intervention with the problem guided by the assessment, and evaluation of the intervention. In contrast, the stages of solution building are a brief description of the concern or problem in the client's words, developing well-formed goals, exploring for exceptions (i.e., successes or times in clients' lives when problems do not happen or are less severe), evaluation of client progress as the client defines it, and end-of-session feedback comprising affirmations of client goals, strengths, and successes and usually a homework "task" based on the client's developing definitions of goals and exceptions.

People develop their sense of what is real through conversation with and observation of others, and, as people interact with and observe one another, their perceptions and definitions of what is real frequently shift, sometimes dramatically.

As De Jong and Miller (1995) point out, solution-focused interviews are unique with regard to the concrete and clearly identifiable questions asked: the miracle question (for amplifying client goals), relationship questions (for drawing out alternative and contextualized client perceptions), exception questions (for uncovering client successes and strengths), scaling questions (for measuring client progress and, in general, helping clients render vague perceptions more concrete and definable), in addition to others. In solution-focused interviewing, careful attention is focused on listening for and exploring the client's words and building the next interview question from the client's latest answer.

The respect shown in solution-focused work for client definitions of reality, as well as for the process of building solutions through the co-construction of "new and more useful" meanings (Hoffman, 1992, p. 18), is readily apparent in the transcripts of interviews. The following case example illustrates questioning sequences in purposeful solution-focused conversations. The reader is asked to pay particular attention to any shifts in the client's perceptions and definitions as the therapeutic conversation unfolds.

Case Example

Lucinda, a 19-year-old, African American mother of two children, was referred to the ther-
apist by a social services worker because she complained about feeling "depressed and stressed out." Her two children, who were three and four years of age, had been removed by protective services and placed in a foster home 18 months earlier. At the beginning of their session, the therapist's information was limited to Lucinda's name, age, address, telephone number, and the fact that she had been physically abused by a former partner. In solution-focused work, minimal information is usually sufficient because the practitioner always begins by exploring the client's current constructions and works from there.

The following excerpts are drawn from a single solution-focused session. The solution-focused procedures being used are identified in italics. (The reader who wishes more complete information about these procedures should see Berg [1994], de Shazer [1985, 1988], and De Jong and Berg [in press].)

**Getting Started**

With belief in client competency and respect for the client's perceptions and frame of reference, the therapist begins by asking Lucinda what she wants from the meeting. Instead of asking "What problem brings you in today?" the therapist assumes that the client is capable of expressing her own construction of a successful outcome for their work together.

Therapist: O.K., what can I do that would be helpful for you?
Lucinda: Well, I've been depressed and stressed out.
Therapist: Yeah, I can imagine.
Lucinda: I just needed someone to talk to.
Therapist: (respecting and exploring the client's words) I can imagine. Is that related to your children not living with you . . . to your stress and being depressed?
Lucinda: Yes.
Therapist: Or is there something else?
Lucinda: Well, the main reason is, 'cause my kids are not with me.

Therapist: I also understand that you were living with your children's father.
Lucinda: No.
Therapist: Some other person?
Lucinda: Uh huh.
Therapist: I understand he has been very abusive to you.
Lucinda: Yes.
Therapist: Is that what happened with the children?
Lucinda: Yes, not exactly.
Therapist: Not exactly. That was a separate thing—between you and him?
Lucinda: Right.

In this dialogue, the therapist asked Lucinda several questions to which she was able to respond "yes." This was purposive because Lucinda's affect seemed depressed and her manner tentative. This type of questioning lets the client know what the practitioner already knows about the client; it also establishes rapport and a pattern for the session whereby the client gives information to the practitioner.

**Co-Constructing a Sense of Competence**

In a solution-focused interview, the practitioner helps the client develop two primary constructions: what she would like to have different in her life and past successes and strengths that the client can use to make desired differences happen.

When first asked to identify what they would like to change as a result of therapy, clients usually respond by stating a problem. For example, Lucinda responded by saying that she was "depressed and stressed out." One way to proceed and return to solution-focused work (after the client has had an opportunity to describe the problem) is to listen for client successes in dealing with problems and then begin to explore these in detail as part of the co-construction process. In the next sequence, the therapist casts Lucinda in the role of being expert about her own successes and their meaning. The therapist does not know where the exploration will lead but trusts that Lucinda, like most clients, has competencies that she has used in the past to confront problems. Consequently,
the therapist conceives her task in the conversation as continuously inviting Lucinda to develop a keener awareness of the successes, strengths, and resources that she might use to make changes in her life. Cantwell and Holmes (1994) call this approach “leading from one-step behind.”

Therapist: And did I hear you correctly that you got out of that relationship?
Lucinda: Yes, I did.
Therapist: (indirectly complimenting a possible success) Wow! I wonder how you did that.
Lucinda: It was hard to do but . . .
Therapist: (affirming Lucinda’s perception) I’m sure it wasn’t easy.
Lucinda: No, it wasn’t.
Therapist: (exploring and amplifying the success) So how did you do it?
Lucinda: I just stayed away.
Therapist: You just stayed away from him? That’s all?
Lucinda: Uh huh.
Therapist: He didn’t want to end the relationship?
Lucinda: No, and I got a restraining order put on him.
Therapist: You did? Was it helpful?
Lucinda: For a while it was, but he just kept coming back.
Therapist: So, he didn’t want to break up?
Lucinda: Right.
Therapist: (trusting client expertise and affirming it) But you knew this was best for you?
Lucinda: Right.
Therapist: So . . . he didn’t want to, he kept coming back, how does he make this happen?
Lucinda: Well, he was threatening me, threatening to kill me and . . .
Therapist: (acknowledging the severity of the situation) Wow.
Lucinda: And every time he sees me he jumped on me.
Therapist: He jumped on you, right. Even after you broke up?
Lucinda: Right.
Therapist: (indirectly complimenting) So that’s when most women sort of become weak and they take him back. How come you didn’t?
Lucinda: A couple of times I did because I was scared. And the more I kept going back to him, it got worse and worse. And then he ended up hurting my son.
Therapist: Oh! Is that what it was?
Lucinda: That’s what caused me to get my kids taken.
Therapist: Right, I see. So your children have been taken away because of what happened with him.
Lucinda: Right.
Therapist: (asking for the client’s definition of the situation) So . . . was that helpful to break up with him or was it not helpful to break up with him?
Lucinda: (in a stronger voice) Yeah, it was helpful. Because I feel that another man don’t have no right putting his hand on nobody else’s child.
Therapist: (respecting and affirming the client’s definition) Right.
Lucinda: And that child, you know, I feel that if that child didn’t do nothing to him, he ain’t got no business putting his hand on him.
Therapist: Wow. You are very clear about that.
Lucinda: Yes. He broke my baby’s leg!
Therapist: (complimenting strengths) Uh huh. Right. But some women, even though he did that, some women would either get scared of him or, you know, somehow think that he’s gonna change and take him back.
Lucinda: No. My kids come first.
Therapist: For you?
Lucinda: Right . . . my kids come first.
Therapist: Really?
Lucinda: And I shouldn’t have to keep taking that abuse. And my kids don’t have to take it.
Therapist: (meeting Lucinda to sharpen her construction of competence and strength) How did you know this? That your kids “didn’t have to take it” and you shouldn’t “have to take it”? How did you know this?
Lucinda: Because if I had stayed with him it would have ended up worse than what it was. Either me or my kids would have been somewhere dead or . . .
Therapist: Wow.
Lucinda: It wasn’t worth it.
Therapist: Really? So, I mean, you knew it, you were very clear about this—that this is not worth it? No man is worth it.
Lucinda: Right, it wasn’t. You know it wasn’t worth it—beat up, walking around with black eyes and my kids screaming and hollering, seeing their mother be beat on—it wasn’t worth it.
Families in Society
June 1996

Therapist: (genuinely impressed and complimenting) It wasn’t worth it. Wow. I’m amazed by this. (continuing to foster the construction of a sense of competence) How did you do this? I mean,

Lucinda: I just stayed away from him, you know. I was scared of him but, you know, my father always told me, “Be strong,” and that’s what I did.

Therapist: Really? That’s what you did.

Lucinda: I stayed strong. And every time I saw him I didn’t run. You know, I let him make all the threats he wanted. I didn’t run. Wasn’t no need for no running. ‘Cause you know you can’t run forever.

Therapist: That is true. Wow. So lots of things happened to you, right? More than most women will go through in their lifetime.

Lucinda: Some women, as you said before . . . they’ll stay with their person, but ain’t no way that I can stay with a man that’s going to constantly keep beating on me, ’cause I don’t like to be beat.

Therapist: Of course not.

Co-Constructing a Sense of What the Client Wants

In solution-focused interviewing, neither the practitioner nor the client usually knows before the interview precisely what the client might want to change in his or her life (goals). Also, neither knows the role the practitioner might play in helping the client to make these changes. Consequently, interviewers usually work back and forth between a client’s emerging constructions of competence and what the client might want different in his or her life. Clearly, the successes and strengths of most interest and use to the client will be those related, in the client’s mind, to what he or she might want different in his or her life.

At this point, the therapist was becoming impressed with the steps Lucinda had already taken and thus turned to some constructionist work around goals:

Therapist: So it’s two years since you’ve seen him. And you want your children back. But in order to get your children back you had to do this. Social service said you had to get Marvin out of your life.

Lucinda: Right.

Therapist: And you have done that.

Lucinda: Yes, I have.

Therapist: (changing focus to goal exploration) And what’s the next piece you have to do?

Lucinda: Get my kids back. My kids is very important to me.

Therapist: Right. O.K. Where do I come in on all this? How can I help? ’Cause, you know, it sounds like . . . you were able to get Marvin out of your life—even though that was very tough. And I wonder how I can help you with your depression and your stress.

Lucinda: You know, I have a lot of things on my mind. Sometimes I be scared.

Therapist: Of?

Lucinda: I be scared to walk out of my own house.

Therapist: Because of Marvin?

Lucinda: Right.

Therapist: So you are still afraid of him? O.K. And you don’t want to be scared anymore? Is that what you mean?

Lucinda: Right

Therapist: What else? How do you want things to be different?

Lucinda: I just want my kids back.

Therapist: You “want your kids back.” Right. What do you have to do so that . . . what do they tell you that you have to do?

Lucinda: I had to go to a meeting or meetings. At the meetings we talk about abusive relationships and stuff like that.

Therapist: Uh huh.

Lucinda: And that’s it.

Therapist: (exploring whether Lucinda perceives attending the meetings as beneficial) That’s it. How helpful is going to that meeting?

Lucinda: It’s O.K. We have it every Tuesday and Thursday.

Therapist: Uh huh.

Lucinda: And it’s helping me a lot.

Therapist: What about the meeting is helpful?

Lucinda: You know, they take a lot of things off my mind. We talk about the abusive relationships and how abusive men are and stuff like that.

Therapist: Does it help you keep Marvin away from your life?

Lucinda: Yeah, it relieves me, you know.

Therapist: It does?

Lucinda: It takes it off my mind and stuff.

Therapist: (exploring other successes) So, that’s been helpful. What else has been helpful?

Lucinda: My father. You know, he talks to me
and stuff. He told me, "Don’t be scared. Just leave it in the Lord’s hands."

Therapist: Yeah.

Lucinda: And, you know, he’ll make a way for that person just to leave me alone. Not physically or mentally, but he’ll just make a way for that man to leave me alone. And that way every time he sees me he won’t harm me or hurt me. He’ll say, “Hi, how I’m doing,” and keep on going.

Therapist: [exploring resources in Lucinda’s environment] Yeah, I see. So, your father gives this kind of advice to you. It sounds like he’s very helpful to you.

Lucinda: Yes.

Therapist: What else has been helpful?

Lucinda: Social workers. They give me advice. And, you know, they always, ‘cause I always talk about my kids and they always tell me don’t say I ain’t gonna get my kids back, ‘cause they’ll be home real soon.

Therapist: And that’s helpful—to hear that, that they’re gonna be home soon?

Lucinda: Right. And they told me the next time I get involved with a man, sit back and watch how that man treat his mother, and then I know how he would treat me.

Therapist: Right. So is that what you’re going to do next time?

Lucinda: Uh huh.

Therapist: So you remember a lot of things it sounds like?

Lucinda: Yes.

Therapist: [returning to goal formulation] Good. I want to come back to this. What can I do that would be helpful? It sounds like you do know, you’re doing lots of things, you have done lots of things.

Lucinda: Just help me see it through. Give me some advice.

Therapist: On?

Lucinda: Help me be strong.

Therapist: Be strong. Sounds like you already are, though.

Lucinda: I think I am.

Therapist: I mean, if you could stand up to Marvin.

Lucinda: It was something hard to do.

As is often the case, clients’ goals are vague and involve someone else doing something differently in order to make their lives more satisfying—a common way in which clients express a sense of powerlessness to practitioners. In response, a solution-focused approach asks interviewers to begin to develop a goal-formulation conversation with clients, inviting them to co-construct a vision of an alternative future that concretely identifies what will be present in a more satisfying future and that focuses on what clients might do differently to make that future happen. The therapist opens the following conversation with “the miracle question” and then uses several other questions to assist the client to amplify the vision:

Therapist: Oh, I’m sure it was very hard. I’m sure it wasn’t easy. But somehow you managed to get Marvin out of your life. And that’s no small accomplishment. Wow. You said you don’t want to be depressed anymore, and you don’t want to be stressed anymore. Let me come back to this. I’m going to ask you a very strange question—I have a lot of these strange questions, maybe you never heard them before. (speaking slowly and pausing frequently in order to allow the client to absorb the parts of the miracle question) Let’s say after you and I talk and whatever you do for the rest of the day and you go to bed tonight and when you are sleeping a miracle happens. And the miracle is the problem that brought you here today to talk to me—about how you want your children back and how you want to be stronger. And all these things happened because of this miracle. All the problems that are related to your children, related to Marvin . . . are solved. But this happens when you’re sleeping tonight, so you don’t know that miracle actually happened. The problem that brought you here is gone, it’s solved, it’s all taken care of. So, when you wake up tomorrow morning, how will you find out . . . what will make you say, ‘Wow, maybe something happened in the middle of the night when I was sleeping; maybe there was a miracle’? How will you be able to say or tell that tomorrow morning?

Lucinda: How would I be able to tell that?

Therapist: Yeah.

Lucinda: To be honest, I wouldn’t know. If a miracle were to happen to me, I wouldn’t know how I’d tell it. I’d just be excited.

Therapist: [exploring the client’s construction by repeating and exploring her words/categories] You’d be excited?

Lucinda: I’d be excited.

Therapist: O.K. That makes sense.

Lucinda: So I couldn’t tell you how I would be able to tell. I’d just be excited, happy.
Families in Society
June 1996

Therapist: (inviting the client once again to construct a definition of something concrete and small that would be present when her "miracle" happened) O.K., so when you open your eyes, when you're sort of coming out of your sleep in the morning waking up from a deep sleep, what would be the first thing that will make you think, "Wow, something must have happened when I was sleeping"?

Lucinda: If a miracle was to happen to me and I woke up, and if it do happen, I hope the miracle would be that my kids would be there when it happened.

Therapist: Ah. So your kids would be in the same place with you, same house with you. That will make you very excited.

Lucinda: Yes.

Therapist: (affirming Lucinda's definition) Good. So suppose that happened.

Lucinda: (starting to smile and in a stronger voice) That'd be exciting. I'd jump for joy!

Therapist: Jump for joy. Great. So suppose you're jumping for joy, you are very happy. That means you are very cheerful, right?

Lucinda: Uh huh.

Therapist: You move, you'd get up, right?

Lucinda: Right.

Therapist: (starting to invite the client to focus on concrete things that she would do) You'd be excited to get up in the morning and do things.

Lucinda: Yes.

Therapist: (inviting Lucinda to expand her miracle picture by asking for her perceptions of how the children would be different when the miracle happens) What would your children be like?

Lucinda: They'd be happy to see me.

Therapist: They'll be happy to see you. O.K.

Lucinda: They won't have to worry about nobody else raising them. They know who their mother is.

Therapist: Yeah, I understand they're in a foster home.

Lucinda: Right. And they wouldn't have to worry about no strange person, you know, telling them what to do and stuff like that.

Therapist: Right. O.K. And so they will be happy and you will be happy. You'll be excited and they'll be excited to be back with Mama.

Lucinda: Yeah, and no strange person laying next to them.

Therapist: O.K., so there will be no strange person laying next to them.

Lucinda: It'll be their mother.

Therapist: (returning the focus to what will be present and what Lucinda will do concretely) Right, it'll be you. What would you do then? What would be the first thing you would do in the morning when this all happened?

Lucinda: I'd grab my kids, give them a hug, tell them I love them. Tell them how much I love them. And how glad, you know, how glad I am to have them back home with me.

Therapist: And what would they be like?

Lucinda: They'd be happy.

Therapist: They'd be happy, too.

Lucinda: Big smile on their face.

Therapist: And you want to see that.

Lucinda: Yeah.

Therapist: I suppose they want to see you smile too, right? They want their mama to be happy.

Lucinda: Yes.

Therapist: What else will be different when this actually, you know, suppose this actually happened?

Lucinda: If it happened things would change for me. I won't be depressed anymore. I won't have to worry about being stressed out anymore 'cause my kids ain't there with me.

Therapist: Right. (asking for what will be present—not absent) What would you be like instead?

Lucinda: I'd feel like a mother should feel.

Therapist: (exploring the client's meanings, not assuming how a mother should feel) What's that?

Lucinda: 'Cause, you know, without your kids, it's a hurting feeling when your kids get taken from you. You know, it hurts.

Therapist: Sure.

Lucinda: And I'd just be one happy parent. You know, one happy mother.

Therapist: And so, when you are not depressed anymore you'll be happier, you'll be a happy mother. What else?

Lucinda: I'd be thankful.

Therapist: Oh, you'd be thankful. To whom?

Lucinda: That I have my kids back. You know, I won't have to worry about going through that . . . or sitting there worrying about when I'm going to get my kids back, when are these people going to give me my kids back. And is my kids going to stay gone forever, and all that . . .

Therapist: Oh, so all that will be gone from your head?

Lucinda: Right.
The therapist understood at this point that Lucinda’s miracle picture involved mainly the return of her children. The therapist also understood (as did Lucinda perhaps more fully) that Lucinda’s stress and depression had a lot to do with her children’s absence.

The therapist continued to invite Lucinda to expand her emerging construction of her “miracle picture.” She asked Lucinda what she would do with her children that would tell her children that she was happy to have them home. Lucinda responded with several ideas about positive parenting, which the therapist took as strengths, asking “... where did you learn to be such a good, loving mother?” Lucinda then continued to sharpen her perceptions about the strengths that she could draw upon to make her miracle picture a reality, telling the therapist how she had cared for her younger siblings since she was eight years old and presenting concrete parenting techniques and general advice that she had received from her father.

At this point, Lucinda made an observation that is typical of many clients with whom we have worked.

Lucinda: (her voice now much stronger) I’ve been through a lot.

Therapist: (truly impressed and indirectly complimenting) Sounds like it. But you also learned a lot. Wow. Amazing. So, you know, I’m amazed by this again. Year and a half, this year and a half, two years with Marvin and with your having your children taken away. That has not been easy.

Lucinda: And then, you know, well I got in a relationship with him after my little sister was buried. So, I guess that’s what made it worse.

Therapist: Your sister was buried?

Lucinda: My 13-year-old sister. She died of asthma.

Therapist: Wow. So I guess you’re right, you have been through a lot. So in the middle of all this, how did you learn to be so strong?

Lucinda: I got a best friend, you know, somebody that’s been there for me, somebody that I ain’t got to worry about her turning her back on me. And when I have problems I know who I can go talk to. You know, somebody who’s just going to be there for me.

Therapist: (affirming her resource) And you had a friend like that?

Lucinda: Right, she’s still my friend.

Therapist: And you also said your father was very helpful?

Lucinda: Right, you know, they was there. They was by my side. You know, they was in my corner.

Therapist: They were in your corner. And that helped?

Lucinda: Uh huh.

Therapist: (inviting Lucinda to think about the meaning she attaches to her supports) So knowing that they were in your corner with you, what about that was helpful?

Lucinda: They just helped me, they helped me focus, keep my mind off a lot of things. Just told me, “Don’t worry about it. Be strong.” Told me I was going to get my kids back real soon.

Therapist: Reminding you that you were going to get your kids back, that was helpful, you say?

Lucinda: Yeah.

Therapist: (inviting Lucinda to identify her strengths and successes) Was there anything that you did that was helpful?

Lucinda: I went to see my kids all the time. I had them every weekend and stuff like that. You know, I was always there for them.

Therapist: Oh, right, so you stayed in touch with them.

Lucinda: Let them know who their mother is, you know. So when I do get them back, they won’t think I’m some stranger or nothing like that.

Therapist: Right. So you made sure that they knew that you’re their mother.

Lucinda: Right.

Therapist: Good. What else did you do to help yourself to stay strong?

Lucinda: I stayed in the meetings.

Therapist: You stayed in the meetings. O.K.

Lucinda: And I was always with my social worker. You know, something that would keep my mind off of everything. I moved around a lot.

Therapist: So, try to keep busy and... 

Lucinda: Right, and just keep my mind off a lot of stuff.

Therapist: Keep your mind off a lot. So, let me come back to this, how did you overcome this fear of going outside and fear that maybe Marvin is, you know, might be jumping on you and stuff like that? How did you learn to overcome that?
Lucinda: Well, like I said before, you know, you got to be strong. And my father always told me to put it in God's hands. He told me I'm one of God's children; I can't be harmed.

Therapist: Really.

Lucinda: And I took his word for it.

Therapist: When you heard this from your father, you put that into practice?

Lucinda: Right

Therapist: You knew how to make it work for you?

Lucinda: Right.

Scaling: Measuring Client
Constructions of Competence

Several authors (Rappaport, 1990; Riessman, 1993; Saleebey, 1992) observed that professionals must find new ways to measure client progress in individual treatment sessions as well as client outcomes in more formal studies of treatment effectiveness. More specifically, these authors emphasize that measurement must respect and incorporate the categories and meanings of clients. In solution-focused interviewing, scaling questions are used extensively to analyze client "meanings" (Berg & de Shazer, 1993). In the following dialogue, the therapist invents a scaling question to measure Lucinda's perception of her own progress:

Therapist: Let me ask you this, let's say on a scale of 1 to 10, 10 stands for how you will be when you finally get your children back, and 1 is what you were like when your children were taken away from you. Remember those days? How bad you felt?

Lucinda: Yeah.

Therapist: Where would you say things are today?

Lucinda: I'd say between 8 and 9.

Therapist: Between 8 and 9! Woah! (reinforcing client's perception of competency) How'd you do that? I mean that's a lot of improvement. Isn't it? (therapist using her note pad as though it were a scale from 1 through 10) I mean how you felt from here to all the way up here?

Lucinda: Yep. I see it. I see my kids coming back home any day now.

Therapist: Oh, you can see it.

Lucinda: And I can feel it. (in a confident, strong voice) I know it.

Therapist: I see. Wow. That's a lot of improvement. (relationship scaling-question) What about your father? If I were to ask your father, where he thinks Lucinda is between 1 and 10 if I was what he saw you were like when your children were first taken away. He knows you very well, right?

Lucinda: He might say 10.

Therapist: He might say 10. So he also agrees with you that you've come a long way.

Lucinda: I see it, you know, 'cause my grandmother, she's a, you know, she's a Christian lady. And she told me, she said she see it and she can feel it, my kids will be home soon. I call my grandmother all the time and that's all I talk about—my kids. She pray with me over the phone.

Therapist: She does? So your grandmother also sees, she can feel that the children are coming home.

Lucinda: My kids is coming home.

Therapist: (affirming and complimenting the supports in Lucinda's environment) So you believe her. You are surrounded by some good people.

Lucinda: Yeah.

Therapist: O.K. In your mind, then, what needs to happen? Your dad, your father thinks that you already are at 10. But in your mind what needs to happen so that you can be up to 10?

Lucinda: Continue seeing my kids. Paying them visits. Gettin' them on the weekends and continue my meetings. And they'll be there.

Therapist: Great. I think I explained to you I'm going to take some time out and think about what you said to me . . . . is there anything you want to ask me?

Lucinda: Not really, no.

After 45 minutes of conversation, the therapist took a break to think about what Lucinda had said and to formulate her end-of-session feedback. The feedback consisted of an affirmation of Lucinda's goal, several compliments that affirmed Lucinda's strengths and resources, and a related task. As she made observations about Lucinda's constructions, the therapist was careful to use Lucinda's words:

Therapist: Well, Lucinda (pause), it seems to me that it's reasonable and natural for you to be depressed . . .

Lucinda: Yes.

Therapist: . . . and stressed out under the cir-
Solution-Building Conversations
Berg & DefJong

Lucinda: Yes.
Therapist: So, I mean, it makes sense to me that you would be . . . depressed, because, as you were saying, your children are everything to you. (implicitly affixing Lucinda's goal) And everything has been taken away from you. So it's perfectly understandable. What’s amazing about you, however, is that you have been through a lot in your life.
Lucinda: Yes, I have.
Therapist: You have been through a lot. A lot's happened to you. And you also say you learn things from that.
Lucinda: Yes, you learn from your mistakes.
Therapist: (complimenting) But what’s amazing about you is that at your age, you’re only 19 . . .
Lucinda: Yes.
Therapist: . . . and you have used what you have learned. You have used what happened to you in your life. You have learned and you have used it to make yourself a better person. And that’s really absolutely amazing to me. For someone as young as you are. And so, I guess, for someone your age you are very wise already.
Lucinda: (smiling, straightening, and with a confident voice) Yes, I am. Because, you know, some young parents, they get their kids taken and don’t even want them back. But me, I think the world of my kids. You know, 'cause that’s all I got.
Therapist: (affirming her goal) Yeah.
Lucinda: And that’s what slowed me down. You know, I had my first when I was 15. You know, maybe God, you know, the Lord thought that was best, maybe He thought it would slow me down, and it did. You know. My first child slowed me down.
Therapist: So again you learned from that.
Lucinda: And like I said, everybody makes mistakes. And I don’t think there’s anyone out there that can tell me they ain’t never made no mistakes. 'Cause everybody make mistakes.
Therapist: Absolutely. And you learned that too. And then you use what you learned.
Lucinda: Right. So from now on I have to think before I act.
Therapist: Right. (complimenting) And the other thing is this—I’m amazed by how you’ve been able to break off this relationship from Marvin . . . you were able to stand up and . . .
Lucinda: I wanted to let him know.
Therapist: Let him know.

Lucinda: You know, you caused me to get my kids taken from me and ain’t no way that . . . you know, excuse my language, but ain’t no way in hell that I would be able to take, accept that man back in my life or my kids’ life after what he done took me through, took my kids through.
Therapist: Right. Well, I think that you are almost there—to 10. As your father says and as your grandmother says and as your social worker says—you are almost there. And I tend to agree with that. You are almost there. And soon you are ready to be at 10. You have come a long way from 1 all the way up to 8 or 9. It wasn’t easy, but . . .
Lucinda: No it wasn’t. It was hard.
Therapist: . . . but you really worked hard to be at that. (suggesting a “task” based on the constructions that emerged in the interview) And so, I guess, obviously you need to keep doing it because you know how to do it and you’ve done it. (putting the client in charge of termination) And I don’t see any . . . you know at this point I’m not sure if we need to get together again ever. What do you think?
Lucinda: I don’t think so. Hopefully things will go right for me.
Therapist: Right. Sounds like it will. Sure sounds like it will.
Lucinda: I hope so.
Therapist: Yeah. Sounds like it will. And it sounds also like you are determined to make it go all right for you and your children.
Lucinda: Right. I just got to put my foot down. And stay strong.
Therapist: That’s right. O.K. Well, thank you for coming. Good luck to you.
Lucinda: Thank you.

Case Summary
This case illustrates how client perceptions and definitions can shift during a purposeful, solution-focused conversation. Lucinda’s initial perception was that she was “depressed and stressed out.” Early in the session, she was passive, answering the therapist’s questions with a simple yes or no. As the therapist respectfully and persistently asked questions and made reality-based observations that implied that Lucinda was a sensible, caring, and competent person, Lucinda was able to expand her repertoire of strengths and resources and what she wanted to happen in her future. By the end of the session,
having co-constructed with the therapist a clearer sense of what she wanted and how to make it a reality, Lucinda decided that she did not need to return. As she put it: "I just got to put my foot down. And stay strong." Presumably, she did just that; Lucinda never called for another appointment, and her children were returned to her.

Outcome Evaluation

Solution-focused therapy has been around for only the past 15 years. Therefore, outcome research is scarce (see Adams, Piercy, & Jurich, 1991). Another outcome study at the Brief Family Therapy Center (BFTC) in Milwaukee has just been completed (De Jong & Berg, in press) that includes data on 275 clients who came for services between November 1992 and August 1993. Outcomes were measured while clients were in therapy and through telephone contacts at seven to nine months after therapy. Because the study was conducted according to a single-group design and no control or comparison groups were employed, the findings must be understood within the context of these limitations. Highlights of the findings and comparisons with other studies are presented below.

Practice Evaluation and Intermediate Outcomes

In solution-focused work, practitioners regularly ask clients the following scaling question: "On a scale of 1–10, whereby 10 is the problem(s) with which you came to therapy is solved and 1 is 'the worst it has ever been,' where is it now on that scale?" This question is useful in developing a sense of client progress.

This scaling question also approximates the single-system design for measuring progress under social-constructionist and strengths-based principles. The question approximates the single-system design by estimating the state of the client's problem at three points in time—when it was the "worst ever" (the baseline), in the future when the problem is solved, and "now." Further measurement occurs when the question is asked in later sessions. The question also respects constructionist and strengths-based principles by accessing client constructions about progress and how it occurred. For example, when a client says that "things are about a 5 right now," the practitioner follows up with questions such as "A 5! What have you been doing differently this week to help you climb to a 5?"

As part of the recent outcome study at BFTC, 10 therapists asked clients this scaling question at each session, then recorded their progress score in the session notes in each client's file. The therapists did this for 81% of all sessions. By subtracting progress scores for clients' first sessions from those for their final sessions, we obtained one measurement of outcome—an "intermediate outcome"—which measures outcome over the course of therapy. (Clients had to attend therapy for at least two sessions to obtain a score on intermediate outcome; 76% of these BFTC clients came for two or more sessions.) A zero or negative score on intermediate outcome indicated no progress or a worsening of the client's problems; positive scores indicated progress.

The scaling question respects constructionist and strengths-based principles by accessing client constructions about progress and how it occurred.

Theoretically, a client's score on intermediate outcome could range from −10 to 10. In actuality scores ranged from −3 to 8. Intermediate-outcome scores were collapsed and labeled as follows: −3 through 0 = "no progress"; 1 through 3 = "moderate progress"; and 4 through 8 = "significant progress." Twenty-six percent of valid cases showed no progress over the course of therapy, 49% showed moderate progress, and 25% significant progress.

Fifty-seven percent of the 275 clients in this study were African American, 5% Latino, 3% American Indian, and 36% White. At the time of their first visit, 43% of clients were employed and 57% were not. Sixty percent were female and 40% male. De Jong and Berg (in press) report no differences in intermediate outcomes by categories of diversity; that is, African American clients, Latinos, Whites, employed,
unemployed, men, and women all showed similar rates of progress.2

Solution-focused practice is conducted in the same way regardless of the client’s presenting complaint or problem. Unlike most other forms of practice, solution-focused therapy does not assume a necessary connection between a client’s problem and its solution. Consequently, notions of assessment and related interventions play a smaller role. De Jong and Berg (in press) also present analysis of intermediate outcomes by type of client problem. This analysis was conducted by operationalizing type of problem as the practitioner’s Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) (American Psychiatric Association, 1994) diagnosis and by using the client’s own estimate of the problem. In both instances, no difference was found in intermediate outcomes by different types of client problems. The outcomes proved to be essentially the same for cases involving depression, suicidal thoughts, job-related problems, family violence, sexual abuse, self-esteem problems, as well as the seven DSM-IV diagnoses on which we had sufficient data for analysis.

Outcomes at Follow-up

Outcomes were also measured at seven to nine months after clients had participated in their last therapy session. After receiving a letter alerting them to the follow-up, clients were contacted by telephone and asked several questions about the usefulness of their sessions at BFTC. Responses were obtained from 50% of the original 275 clients. Clients were asked whether their treatment goal was met; in those cases in which clients said it was not met, clients were asked whether any progress had been made toward the goal. This line of questioning resulted in three categories of response: “treatment goal met,” “some progress toward treatment goal,” and “no progress toward treatment goal.”

Using this measure of outcome, the BFTC study found a 77% “success rate,” with 45% of contacted clients saying that their treatment goal was met and another 32% indicating some progress toward their treatment goal. The average number of sessions for these clients was 3.0. The study also found no differences in success rates by categories of diversity. Success rates also did not vary significantly by type of problem or DSM-IV diagnosis.

Comparisons with Other Studies

A similar outcome study was conducted at BFTC (Kiser, 1988; Kiser & Nunnally, 1990). Kiser’s study involved contacting 164 clients at 6, 12, and 18 months after termination of therapy. Kiser relied on a question to measure outcomes similar to the one cited above because he wanted to make comparisons with the results of a study at the Mental Research Institute (MRI) in Palo Alto, California, that had measured outcomes in a similar manner (Weakland, Fisch, Watzlawick, & Bodin, 1974). Kiser found highly successful outcomes. De Shazer (1991) gives this summary of Kiser’s result:

We found an 80.4% success rate (65.6% of the clients met their goal while 14.7% made significant improvement) within an average of 4.6 sessions. When contacted at 18 months, the success rate had increased to 86%.

This rate of success is higher and required fewer sessions than that reported for the MRI study, which reported a success rate of 72% over 97 cases, with 40% of clients experiencing “complete relief of the presenting complaint” and 32% making significant improvement. The average number of sessions for the MRI clients was 7.

In summary, available outcome data on solution-focused practice suggest that it is an effective way to work with clients. Although both studies at BFTC were conducted without control or comparison groups, their “success rates” compare favorably with the average success rates reported in Lambert and Bergin’s (1994) meta-analysis of outcome research on the range of practice approaches in use today. Lambert and Bergin, who report primarily on outcome studies using experimental designs with controls, indicated that on average 66% of clients who received some form of therapy showed improvement. (They also indicate that

---

2. Pearson chi-square tests were calculated for several client characteristics in relation to outcomes in this study. Statements of “difference” or “no difference” are based on the results of running this test of significance.
34% of persons in the control groups improved without therapy.) The success rates in the BFTC studies compare favorably with these percentages. Although this is a promising comparison indicating that clients receiving solution-focused therapy report change rates at percentages comparable with change rates in other more rigorously tested populations, the effectiveness of solution-focused therapy remains to be demonstrated using controlled experimental designs to establish the internal validity and efficacy of the treatment. We hope that the study reported here will prompt further evaluations of this kind.

Linking Solution-Focused Procedures And Social Constructionism

Social constructionism is a metatheory about people's interpretations of the world and their experiences. As such, it encompasses other theories about how and why people have particular cultural, social, and personal meanings. Hoffman (1990) states, "Social construction theory is really a lens about lenses" (p. 4).

Metatheory is far removed from the realities of work with clients. Solution-focused procedures arose out of many years of treating clients, observing outcomes, and thinking critically about treatment procedures; they were not deduced from existing theory. However, social constructionism theory and solution-focused procedures are connected.

Belief in the social construction of reality. Hoffman (1990) states that many therapies otherwise thought to be in tension with one another can stand together under the broad umbrella of social constructionism. This can be the case "as long as their practitioners agree that all therapy takes the form of conversations between people and that the findings of these conversations have no other 'reality' than those bestowed by mutual consent" (p. 4). The case illustration and comments indicate that solution-focused therapy belongs under this umbrella.

Language as the medium through which personal meanings are expressed and constructed. Stagoll describes social constructionism as asserting,

There is no access to any absolute reality or foundation outside of language; language does not merely mirror reality, but it is our major means of constructing what we perceive as "reality." . . . Reality consists of interpretations which arise from dialogue between interacting participants (quoted in Cantwell and Holmes [1994, p. 18]).

The relationship of language to the client's construction of meaning is complex and deserves ongoing study. De Shazer (1991, 1994) articulates the role that language plays in solution-focused therapy.

Solution-focused procedures arose out of many years of treating clients, observing outcomes, and thinking critically about treatment procedures, not from existing theory. However, social constructionism theory and solution-focused procedures are connected.

Client change through the discovery of new meanings. Social constructionism maintains that clients change by developing new meaning constructions. Different therapies use various procedures to foster new, more useful constructions. Anderson and Goolishian (1992) use a posture of "not knowing" or "genuine curiosity" about the client's constructions. Andersen (1987) uses the "reflecting team." Epstein and White (1990) describe procedures that "externalize the problem." In contrast, this article shows how new meanings arise out of solution-focused conversations initiated by a therapist asking the miracle question, exception questions, and scaling questions.

The client as expert, the practitioner as "leading from one step behind." Gergen (1985) points out that social constructionism challenges many of the assumptions of "the traditional Western conception of objective, individualistic, historical knowledge" (pp. 271–272), a conception highly influential among social scientists and therapists. A fully developed metatheory of knowledge more consistent with social constructionist assumptions has not yet been developed. However, upon completion, it surely will involve an emphasis on contextualized knowledge—knowledge about people that is rela-
Solution-Building Conversations
Berg & Dejong

tive to time, place, and individual. Bloor (1983) offers a promising beginning toward such a theory based on the work of Wittgenstein.

At the level of therapy, respect for contextual knowledge means encouraging the client to be the expert about his or her own meanings. Because only clients possess knowledge about the details of their current perceptions, definitions of reality, and past experiences, the therapist's task is to ask questions that elicit these perceptions and definitions. In solution-focused therapy, the therapist invites the client to be the expert by listening for, repeating, and exploring the meaning of the client's key words and by building the next therapeutic question from the client's latest answer. In these conversations, the client is invited to act as "knower"; the therapist keeps the conversation going by "leading from one step behind" (Cantwell & Holmes, 1994, p. 20).

**Taking a collaborative stance.** Social constructionists, in part because of their misgivings about scientifically acquired knowledge, are skeptical about practitioners having *a priori* expertise sufficient to categorize and solve client problems objectively. Instead, they maintain that client constructions about problems and solutions are essential to effective therapy and that the therapist's role is one of collaborating with clients. Goolishian and Anderson (1991) state that therapy informed by social constructionist thinking becomes

a collaborative and egalitarian process as opposed to a hierarchical and expert process. The therapist's expertise is to be "in" conversation with the expertise of the client. The therapist now becomes the learner to be informed, rather than a technical expert who knows.

Solution-focused therapy shares this commitment to collaboration. In the interview presented earlier, the therapist collaborated with Lucinda's expertise by asking questions that consistently put the therapist in a "not knowing" position (Anderson & Goolishian, 1992) and by affirming and complimenting Lucinda's view of her life.

**Use of reflexivity.** Lax (1992) defines reflexivity as "the act of making oneself an object of one's own observation" (p. 75). Social constructionists point out that reflexivity is closely tied to people's tendency to reshape and expand their meanings. By virtue of their capacities to abstract and use language, clients, for example, can climb outside themselves and reflect on how they are functioning in their particular life contexts, how they are perceived by others, how they might act differently, and so forth. Such reflexivity can open up new meanings and increase the possibility of client change.

Different therapies attempt to stimulate client reflexivity in different ways. Andersen (1987, 1991) introduced the idea of a reflecting team wherein clients are invited to hear the reflections of a team of practitioners about their own case. In contrast, solution-focused therapy uses "relationship questions." For example, the therapist invited Lucinda to draw on her capacity for reflexivity by asking, "If I were to ask your father where he thinks you are between one and ten, where would he say you are?" Lucinda then described her improvement as she perceived her father saw her, a second lens through which to view herself.

**Emphasis on client strengths.** Franklin (1995) points out that Saleebey uses social constructionism in the "strengths model" — a model that asserts that clients and their environments possess strengths and resources that practitioners and clients can cooperatively explore and apply to problems. The strengths model is social constructionist in its insistence that problems are social and that individual constructions can be reframed in ways beneficial to human well-being:

Rather than accepting our self-imposed definitions of human problems, we can radically shift our perspective from the negative to the positive pole. Instead of asking questions that direct our attention to the deficiencies and limitations in human situations, we can choose to ask questions with positive loading. For example, instead of asking, "What's wrong with this individual?" we can ask, "What are the strengths that have helped this person survive? What are her aspirations, talents, and abilities?" (Saleebey, 1992, p. 22).

In Lucinda's case, the therapist invited Lucinda to move from the negative pole to the positive pole. Solution-focused procedures used to open up and amplify client strengths and successes include the miracle question, exception questions,
coping questions, "what's better" questions, in-session compliments, and end-of-session feedback composed of compliments and tasks drawn from emerging client definitions of competence. De Shazer (1994) states that solution-focused therapy as a whole represents a shift from "problem talk" to "solution talk."

Solutions are co-constructed. We have come full circle. We began this article by stating that social constructionism is rooted in the idea that people's meanings are formed in interaction with and through conversation with others. That is, new and more useful meanings are "co-constructed" or, as Weick (1993) states, "The act of dialogue is the vehicle through which meaning gets made" (p. 25). De Shazer (1994) similarly perceives solution-focused therapy as a process of co-construction. Drawing from the ideas of Russian literary critic Mikhail Bakhtin, he states:

Bakhtin's perspective leads to the idea that the relations between therapist and client continue to alter in the very process of the conversation. There is no ready-made meaning that is transferred or handed over from one to the other. Rather, meaning develops or takes form in the process of interacting. A message is not transmitted from one to the other but "constructed between them, like an ideological bridge; it is constructed in the process of their interaction" (Bakhtin, 1928, quoted in Todorov) (de Shazer, 1994, p. 52).

REFERENCES


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


Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.