

## **Working with Mandated Substance Abusers: Language of Solutions**

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## **Working with Mandated Substance Abusers: The Language of Solutions**

**Insoo Kim Berg and Kathryn C. Shafer**

The past decade has seen an increasing number of clients who have been mandated into substance abuse treatment by various sources. The criminal justice systems increasingly views diversion to substance abuse treatment as a viable alternative to incarcerations because of the possibility of rehabilitation, especially for those first time offenders, and as a lower cost alternative to imprisonment (Massaro & Pepper, 2000; Vigdal 1995). The changing public assistance requirements have also led to a growing number of substance abusing individuals who are mandated into treatment in order for them to receive benefits. Many other individuals are brought to the attention of substance abuse treatment centers through child welfare agencies. Since 1976 child welfare departments across the country have seen an increase of more than 330% in child abuse and neglect reports. It is estimated that at least two-thirds of the families known to child welfare agencies have substance abuse problems (Howard, 2000). Clients are also mandated into substance abuse treatment by employers for poor work performances, and many individuals are forced into treatment by their family members. Therefore, there is a need for a practice model that not only elicits the cooperation of clients, but also empowers them to take responsibility for their own solutions.

This chapter introduces clinicians to Solution-Focused Therapy (SFT) and the language and practice skills useful when working with clients who are mandated for substance abuse treatment by external authorities. It will first define and clarify the language and practice methods used in the traditional, problem-focused approaches, and then offer an alternative view from the solution-building perspective (DeJong & Berg, 1998). Next, the chapter provides useful practice techniques for building client-centered, empowering, therapeutic relationships with mandated individuals. Case examples will illustrate how to negotiate workable goals, enhance a client's motivation for change, and build solutions that are acceptable and more readily implemented by mandated clients.

### **CURRENT PERSPECTIVES ON MANDATED CLIENTS**

The language used by mandated clients in substance abuse treatment often mirrors the language of the criminal justice system. Mandated clients often describe the treatment as "doing time." They focus on the "release date," and are more concerned with meeting the requirements of what is recommended by the judge, probation officer, child welfare, public assistance, the employer, the family, or some other monitoring authority, than with the successful completion of clinical goals established by the treatment center. The flip side of this is the language used by treatment providers to describe the mandated client. Words such as "mandated," "involuntary," or "criminal justice" invoke certain attitudes in clinicians, such as, "difficult," "resistant", "oppositional" or "defiant," as well the other commonly used description of clients: "in denial," or "minimizes the seriousness of the problems." It does not take a big leap to then interact with the client in a manner that assume that these descriptions are true. Before long, the client truly displays many of the signs of being "noncompliant" and having a "bad attitude."

Frustrated clinicians often wonder, "How can I make this client admit that he is in denial?" "What can I do to make her think about her kids first before she goes for the drugs again?" "How can I help him see that following a schedule and maintaining abstinence will help him keep a job," or "stay out of jail?" Even though, on a cognitive level, most experienced practitioners know that no one can change another person, when faced with "resistive" clients who are literally killing themselves with alcohol or other drugs, or harming their children or other people, it is extremely difficult to admit that one is helpless to change others. However, only the clients can change themselves; the job of the clinician is to attempt to help clients identify and move toward change that is congruent to their own idea of what is "better" for them.

### **CLINICIANS' VIEWS OF THE MANDATED CLIENT**

Because most current treatment models have been developed based on clinical work with voluntary clients, existing literature is generally not helpful in providing guidelines on how to work with mandated or involuntary clients (Ivanoff, Bluthe, & Tripodi, 1994). What is indicated in the literature is the need to engage clients through active listening and empathy; once trust and

cooperation are established, only then is the clinician encouraged to move on to problem solving. While this approach may be appropriate for many clients, it does not necessarily work for those who are forced into treatment by others. Such clients often feel that they have been unjustly and unfairly treated by the system, and may not stay around long enough to develop a trusting relationship with a helping professional. They are often not convinced that suggested changes are helpful or useful to them. What's more, at times they view them as even harmful.

Many complaints of staff "burn out" stems from the practitioner frustration at knowing their own limitations to make a difference and feeling like they are fighting a losing battle. When the clinician or the treatment program has an agenda for the treatment outcome for the client, "resistance" by all parties involved seems to grow, and the "successful outcome" becomes more elusive. Discouraged by the continued breaking of promises, involvement in criminal activity and relapses, family members, employers, treatment providers, and the clients themselves give up, believing that a client must "hit bottom" in order to become motivated to change (Fishman, 1995).

More recently there has been growing literature advocating the need for a better fit between client motivation and the services provided (Procheska, DiClemente, & Norcross, 1992). Trotter (1999), for example, suggests that practitioners pay attention to the positive or pro-social comments or behaviors that clients show and openly praise them. He also emphasizes challenging or confronting anti-social comments or behaviors, but doing so cautiously. Rooney (1992) advocates a four stage process: 1) emphasizing client choice wherever possible, 2) informing clients about what to expect during treatment and their part in it, 3) contracting around goals and treatment procedures, and 4) fostering client participation throughout treatment. These strategies offer greater degree of choice and control to the client, orient them to the treatment process, and give them a sense of responsibility for the success or failure in achieving the treatment goals that they themselves have established.

DeJong & Berg (2001) support the work of Rooney (1992) and believe that giving a

client a sense of choice and control is essential when working with those who are mandated into treatment. Moreover, they contend that solution-focused therapy sheds a different light on client goals, introducing new perspectives on thinking, motivational interviewing for change, and how to interview the mandated client, as can be seen in the following sections.

## THE SOLUTION BUILDING PROCESS

The traditional problem-solving paradigm, also described as the scientific or medical model, begins with assessing or identifying the problems in detail. It is based on the belief that an understanding of the problem will aid in the next step of selecting the matching solution(s). This second stage is the task of the expert. It is generally thought that the finer and more detailed the biopsychosocial assessment or diagnosis, the better we will be at finding the fit between the problems and solution. The third step consists of the clinician prescribing or recommending the solution to the client who then must agree to implement the procedures in a given time frame. The fourth and final step involves an evaluation of the progress of treatment, making finer adjustments as new information emerges, and if necessary, changing the course of treatment (DeJong & Berg, 2001). This certainly is a reasonable process when the client is voluntary, or is desperate for guidance and has some investment in changing. However, most mandated clients usually do not want to stay in treatment long enough to see the results, nor do they see the benefit of following suggested remedies that they typically see as useless, inconvenient or even harmful. Thus, there is a fundamental disconnect between what the expert clinician believes is helpful to the client, and what the client wishes or believes is helpful to them. When this occurs, it is usually the client who is labeled "non-compliant," "resistive," or "oppositional and defiant."

In contrast, the Solution-Focused Therapy (SFT) practice begins with finding out what the client wants. It asks clients what is their view of their own future; how do they want their lives to be different? How confident are they that they can make these changes happen? These questions set the direction and tone for the treatment endeavor. SFT (De Shazer, 1985, 1988, 1994; Berg & Miller, 1994, Miller & Berg, 1995, Berg & Reuss, 1997, DeJong & Berg, 2001) is a therapeutic model, developed inductively and qualitatively, based on what clinicians observed as effective in clinical settings. It is easy to see why this solution-building process is described as collaborative, since the client takes an important role in setting the direction and making necessary changes according to their idea of how they want to shape their life. Research studies (Gingerich & Eisengart, 2000; Lee, Sebold, & Uken, 2002; Lindfors & Magnusson, 1997; Uken

& Sebold, 1996) have found that SFT approach has similar and/or better treatment outcome with fewer number of sessions than traditional approaches, and that it reduces recidivism rates among incarcerated men and domestic violence offenders resulting in substantial savings in prison expenses and social cost.

Because the client's goal plays a significant role in the treatment process, solution-focused approach pays a great deal of attention to the process and outcome of the goals that the client wants to achieve. This first step opens the client's thinking to all the possibilities and choices that life has to offer (miracle questions), and what they want out of life. The second step is to find out what the client is capable of doing toward accomplishing these goals. This is accomplished through learning about the past and current successes (exceptions to problems), and finding out the details of how and what steps the client has taken to make any small but significant step toward their goal. The third step is to keep clients on the success track by helping them monitor how they are doing at moving toward their goal (scaling questions). Since the clients are setting their own goals and the pace of how to achieve them, according to their own dreams and aspirations and based on their own understanding of personal and situational limitations, clients' resistance is greatly diminished, or non-existent.

People are usually much more invested in implementing their own ideas, not those imposed by someone else, and the more respected one feels, the more confident one is in carrying out even a difficult task (Shafer & Greenfield, 2000). This notion is consistent with the social work philosophy of "beginning where the client is" and respecting client's "right to a self-determination." It is clearly more productive for the practitioner to begin cooperating with the client first, and not making "the resistance" an issue in treatment.

Language, beliefs, and imagination are tools that people can use to negotiate and transform the meaning that events or incidence hold for them (Shafer & Greenfield, 2000). Thus paying close attention to the exact words, beliefs, and images clients use to describe themselves and their lives makes it possible for clinicians to gain access to the client's inner world.

Language can help design steps for solutions to fit the client's frame of reference. Helping

clients see themselves living in a new way can help pave the way for them to actualize this perception.

In the traditional problem-solving approach (DeJong & Berg, 1998, 2001), therapists unwittingly encourage clients to emphasize undesirable part of their lives by focusing on the details of the problems that brought them to treatment, thus highlighting their deficiencies rather than whatever competencies they may have. While this traditional view maintains the stance that talking about problems "dis-solves" them, such problem-focused conversation often highlights the client's failures. Through talking, we selectively build and ignore certain aspects of the story, thus creating a sense of reality and reinforce a belief in the existence of certain problems or solutions. Each repetition of the same story, both positive and negative, makes the story more real and reinforces the sense of failure or success. It is easy to see how detrimental it is to focus only on the problems when working with substance abusing clients who are mandated into treatment since they already have experienced numerous failures and disappointments. Therefore, instead of focusing on clients' past failures or deficits, focusing on even a small "success," such as a time when they had a week, or even a day, sober, becomes a step that can be built upon further (Berg & Reuss, 1997).

### **THE SOLUTION-FOCUSED TREATMENT APPROACH**

The following treatment steps are suggested in order for practitioners to effectively "begin where the client is" when working with mandated clients.

#### Assess the Person, Not the Problem.

The traditional social work concept of "looking at the person in the environment" has made a tremendous contribution to the notion of the importance of assessing the person first, and not the problem. It means paying attention to the client's expertise regarding the circumstances that led them to being mandated to treatment, thus respecting his/her way of understanding and making sense of their world. It also means listening to the clients' understanding of what led to their present life situation, and finding ways to utilize this understanding, without correcting or educating clients on their "wrong" or "inadequate" understanding of the seriousness of their

problems. It also means finding out what is important to the clients, what they value, what beliefs they have of themselves, and what they want in life.

The following questions are useful in helping the client "see" how they are thinking about their problem:

Tell me about your family, and how do you spend your time? What are your best traits?

Who is most supportive of you? What kind of previous treatment experience has been most helpful?

What is your understanding of what led to your coming to this agency (center, program, hospital, prison, etc)?

Would you please describe, in your own words, what led you to come to see me today?

Whose idea was that you should come and talk to me? What is \_\_\_\_ (the judge, your wife, your job, child welfare, etc.) expecting to come out of your meeting with me that would be useful to you?

What were you hoping would come out of your talking to me?

How could the judge (probation officer, etc) tell that your talking to me is helpful to you?

When asked the above questions, the client frequently shows a considerable degree of understanding, and responds in a positive and cooperative manner that indicates an ability to differentiate what is confrontational and what is not. In the process of talking about solutions, clients voluntarily offer information about the way they see the problem. Some clients may respond in the manner that the practitioner may not approve of, such as being evasive, "minimizing the problem," or blaming others for their problems. Rather than being offended by such answers, or immediately labeling the client as unmotivated or lacking insight, it is more helpful to further explore how the client sees his/her situations from his/her perspectives.

The following dialogue exemplifies how worker's questions can shape the client's answers:

Ruth: I don't know what you can do for me. I don't even think I belong here. Nothing against you personally, but you know, I really am not an alcoholic, like most people think

I am. I am a good mother, you know. I just lost my head and got carried away and got a little rowdy. Don't get me wrong. I'm a good mother and I try my best, but somebody got this idea that I'm a bad person.

Worker: I can see that it is very important for you that you are a good mother. I can also see that you are the kind of person who knows what you are and what you are not. It's important to know the difference. So, I'm impressed with how you decided to come here even though you realize that you may not belong here. What made you to decide to come here today?

Ruth: I was told by that judge that I have to come here if I want my children back with me. The judge don't know nothing about me. He never saw me before, so how can he decide I'm not a good mother? But he says I have to come here. So I came and I don't want to lose my kids because they are everything to me.

Even if the client says, "I don't belong in a place like this," the worker can stay neutral and continue to negotiate the client's goal while remaining supportive.

Worker: I'm really impressed that you decided to follow through on this judge's order even though you disagree with him. I guess you are one of these people who really want to do what's right and what's good for you and your children.

By casting the client's protest as reasonable and sensible, it is easy to return to the negotiation of what the client wants in more detail. Certainly getting the credit for keeping the appointment is not likely what the client expected to hear. Such statements cast a positive tone to the interaction.

From this brief exchange, it is clear that Ruth values her role as a mother and that it is very important for her to keeping her children. Knowing this about Ruth, the worker can continue further conversation about what Ruth values, what she might be motivated to work toward, and where she learned to be such a "committed mother." Once Ruth establishes her identity as a committed mother, she is more likely to want to work toward preserving this important identity. By staying with what is important to Ruth, the worker can then explore what

is the client's understanding of what she is supposed to do once she arrived at the treatment program and how her children will benefit from whatever she will decide to do as a result of this conversation.

### The "Not-Knowing" Posture

The "not-knowing" (Anderson & Goolishian, 1992) posture assumes that clients have certain knowledge and expertise about their own life circumstances that led them to being mandated for substance abuse treatment, and that they basically know what to do in order to achieve their goals without needing to be told what to do. Utilizing the client's knowledge, clinicians can help a client like Ruth to build her own future in the way that she believes is good for herself and her children. In doing so, the worker learns the client's frame of reference, how the client thinks, what she believes in, and what aspirations, hopes, and dreams she might have. Getting to know and connecting with the client also means accepting his or her perceptions and disagreements that they might have with the mandating authority without the clinician having to defend or take sides. This approach allows the client to be the "expert" of his or her life (Shafer & Greenfield, 2000). The following questions help clients to identify the step-by-step process of what needs to be done to achieve the goals that they have established for themselves:

Which part of what you were told to do by coming to this agency do you agree, and which part do you disagree with?

**Comment:** By separating the list of mandates the client is required to do, the practitioner helps the client to sort out what they might be willing to follow through first.

What are you hoping I can do to help so that you will get your children back? Can you tell me exactly what I can do to be helpful to you?

**Comment:** By eliciting more detailed clarification of what the client wants from the encounter, the worker clarifies further what the client is motivated to do first. It is important not to assume that professionals know what is best for the client.

Suppose you get your children back, what would they say they like best about living with you again this time?

**Comment:** By bringing in the children's perspective of what they want from their mother, the worker is inviting the mother to look at a wider view of who else is invested in the client's success. Rather than making demands that the client change, the worker addresses the mother's relationship with her children by asking her to think about her children's views on what will improve their lives. This indirect approach reduces the need to confront the mother, without letting her "off the hook." It also addresses the important issue that was already established by the mother. This sort of questioning assumes that the client may or may not agree with the mandate for treatment, and that the practitioner is willing to listen to both sides of the story. Such a neutral position taken by the practitioner reduces the clients' need to defend their position, or attack the mandating authority.

So, now that you got here, what do you suppose needs to come out of this meeting today, between you and me, so that this is useful to you?

Suppose your children were here and I were to ask them, "what do you want your mom to do today that would be most helpful for you," what would they tell me?

What would your children tell me they like the best about the things you do with them?

**Comment:** By asking about the client's desires and hopes for the meeting, the clinician immediately frames the meeting as potentially "useful" to the client, not something that just needs to be tolerated. The clinician is interested in learning about what and who the client values as important. Frequently, bringing other people's perception into the conversation makes the focus much more relevant to the client, even though those people cannot be present physically. In the case of Ruth, since the worker has previously learned that her children are important to her, the focus is on the relationship between her and her children. Such approach reduces the opportunity for the client to resist or engage in a combative or uncooperative relationship.

#### Finding Ways to Cooperate with the Client

Cooperating with the client means learning how to stand side-by-side with them, not facing against them as if in a competition. It is our professional obligation to honor and cooperate with the client first, thus "leading from one-step behind" (Cantwell & Holmes, 1992). Doing so requires that we see things from the client's perspective, thus eliminating the "professional posture" of judging the client. The client does not need one more failure, or another label of being an "incompetent" or "difficult" person. During the initial contact, the most important contribution a practitioner can make is to shape the client's experience to be different from any other negative professional experiences that they may have encountered in the past. The client needs the opportunity and latitude to make choices, instead of feeling coerced to comply; to feel understood, instead of being labeled. This side-by-side approach supports the client's choices, as well as the client's acceptance of responsibility for the consequences of these choices (Shafer & Greenfield, 2000). By viewing the world from the client's perspective, while maintaining one's own, the clinician is able to help the client build a bridge from their world of failures and loneliness, to a sense of belonging, and feeling that they can, as one client explained, "walk tall, with my head up straight."

### **ASSESSING FOR SUSTAINABLE SOLUTIONS**

All clients have some ideas for solutions to their difficulties: some may be reasonable and realistic; others outlandish. Of course, when the client's ideas for solutions are reasonable and realistic, it is easy to be supportive and encouraging. Maintaining a respectful stance toward the client means, however, that the practitioner must withhold his/her judgment when the client's solutions seem outlandish or unrealistic, and to continue to ask many open-ended questions to elicit the client's ideas more fully.

The following case suggests some useful questions when the client seems unrealistic in his/her assessment of what is doable:

Andre and Melinda are a young couple with two small children living in a semi-rural area with no public transportation. Melinda worked in a nursing home, a job that she found extremely stressful. As her feelings of being trapped and stressed increased, so did her

drinking, especially on her way home from work. One day on her way home, she was stopped by the police because of her weaving erratic driving behavior and arrested for drunk driving. Melinda lost her driving license and she was told that she must attend mandatory Driving Under the Influence [DUI] classes in order to regain her driver's license. In addition, she had to pay a hefty fine and fees for the classes.

In reaction to the financial pressure, she began to drink more. During a loud, shouting match with Andre about his lack of support, and lack of money, the police were called by a neighbor who heard her threatening to harm the children, herself, and to "end it all." The police called social services and the children were temporarily placed with their maternal grandparents who live nearby.

Shamed and remorseful, Melinda found herself in deeper despair and in more financial trouble. She promised to do everything the mandating agents demanded from her: attend the DUI class for 10 weeks; visit the children daily at the grandparents house 5 miles away, and keep her job, about 15 miles away - all without any means of transportation since Andre needed to use his truck in his long hours of work in construction. Melinda agreed to go to couple counseling with Andre, there she was told that she needs to work on her drinking problems and her anger at the world. After her session with the counselor, Melinda attempted to end her troubles by overdosing on medications she obtained from the nursing home. She was rushed to a hospital emergency room and was discharged the following morning, with a recommendation to follow-up with outpatient treatment. Melinda readily agreed.

Is it realistic to expect Melinda to accomplish all these goals? Of course not! It is not only unrealistic, but setting the client up to fail, one more time. One can easily imagine how Melinda would be easily tempted to drive without her driver's license, thus compounding her problems even more. A sensible clinician would question the client's willingness to comply with all the suggestions and requirements that were generated out of desperation, rather than based on a realistic assessment of what is manageable. Doing more is not always helpful to a

client. In situations like this, the practitioner's taking a "not-knowing" posture can help clients assess how realistic it is for them to agree on all the recommended services:

I wonder, what do you know about yourself that tells you that you can do all these? It seems like an awful lot for anybody to do.

Can you explain to me how you are planning to get to these places without a car?

I can see that you cannot quit your job because you are concerned that you may not earn the same wage you are earning now, even if you find another job closer to your home.

With this in mind, can you tell me in more detail what are some of your ideas on how you plan to accomplish all this?

Knowing you as well as he does, what would Andre say about how likely it is that you are going to be able to do all this?

If I were to ask your best friend, you say her name is Laurie, what would she say how confident she is that you can do all this?

Of all the things you need to do, what small thing can you can do right away that will make the greatest difference in your life?

What will tell you that you are making progress?

### **EXCEPTIONS TO PROBLEMS**

The basic assumptions of SFT is that all problematic situations, even long standing and chronic problems such as substance abuse and mental illness, contain periods when these problems either do not happen or are less severe. It is the clinician's task to uncover these circumstances during the initial conversation thereby helping clients recognize that they have had times when they could have gotten drunk, took a pill, or lashed out at someone, but somehow managed not to do so. Such an *exception* is a significant indication that the client can repeat this small success, and even expand on it. The important step is for the clinician to ask about the details surrounding the exceptions, the "forgotten successes," which allowed for the successful mastery of a problematic behavior or an urge. A detailed discussion of how the client was able to have a day of sobriety

reminds the client of all the steps he or she had taken to be successful, even for a brief time period. Such detailed recounting of his success helps the client to be able to repeat these steps.

Some examples of useful questions during this phase of conversations are:

Worker: I can see that you are very concerned about your tendency to promise yourself that you are not going to drink and then you end up drunk. This certainly can be pretty discouraging, I'm sure. So, tell me about the most recent times when you made this promise to yourself and you were able to keep your word to yourself?

Todd: I don't know . . . it seems like I've been doing a lot of drinking lately.

Worker: So, when would you say was the most recent times when you could have gotten drunk but somehow you decided against that?

Todd: I guess last week, Friday night. Of course I showed up at the bar as usual, but you know, I decided that I wanted to know what I was doing and not make a fool of myself as usual when I get drunk. I sat there and drank soda instead of my usual stuff of booze. I was sure other guys were going to razz me about drinking soda, but you know what, nobody said nothing. I was surprised. I got to thinking about this and I guess they all know how much I drink and what happens to me when I do. I guess it's not a pretty picture.

Worker: Wow, sounds like you learned a lot from this little experiment Friday night. You could have easily fallen into the usual Friday night habit, but what made you decide that you wanted to drink soda instead?

Todd: I just wanted to find out if I could do it or not, you know, you wonder about that sometimes, you know what I mean?

Worker: Yeah, many people tell me the same thing that you are telling me now. So, what did you learn from this little experiment?

Todd: What I learn from this is that I must have looked pretty stupid when I get drunk and nobody told me that before. Actually my family has been telling me that, but I

usually don't listen to them. I sat there and watched everybody and some of my old drinking buddies looked pretty stupid, all slobbering and wobbling when they walk and stuff like that.

Worker: So, say that again, what did you learn about yourself from this experiment?

Todd: I'm sure I looked just as dumb as all these people at the bar and I decided that's not me, I don't want to be that stupid anymore. That's why I'm here.

Worker: I see you already have a pretty good sense of what you want to be and what you don't want. I would say you have a very good start. So, what kind of person do you want to be instead?

Todd: I'll tell you that I don't want to spend my life being a drunk. I messed up my life already but maybe I can turn things around yet, I'm still young and maybe there is a hope for me.

Once this exception to problem is identified, as with Todd's decision not to "make a fool of myself" and somehow having had enough control to stay away from "drinking as usual," the important task is to discuss how to maintain the current level of success and how such ability may change other aspects of the client's life. Such exceptions point to potential solutions that clients do not even realize that they are capable of. When clients recognize these forgotten successes, they become more confident of their abilities, thus reinforcing further resolve to repeat the successes. At times, just recognizing small successes is enough to instill a sense of hope about their future and their own capacities to achieve change.

### SCALING QUESTIONS

It is a common human impulse to measure, score, and compare ourselves with others. Taking advantage of this human tendency to measure and compare, asking *scaling questions* invites clients to step back and assess their own situation in various areas, such as their level of motivation to change, how much progress they have made toward their goals, how hopeful or

optimistic they are in their abilities to achieve the desired goal, the seriousness of the problem, feelings of confidence or level of depression over time, and a host of other issues that surface in treatment.

The use of the following scaling questions (DeJong & Berg, 1998; Berg & Reuss, 1997; Berg, 1994, Berg & de Shazer, 1994) encourages clients to stand back and helps them assess their own situation more objectively. Below are some examples of scaling questions that might have been used with Melinda and Ruth:

I am going to ask you a different kind of question this time. Let's just say that 10 stands for how you want your life to be, that is, get your children back from the foster home, have a place of your own, and feel and act like a good mother that you want to be. That's 10. Now 1 stands for how terrible you thought your life was when you were in the middle of drug use and your life fell apart. Those days stand for 1. In terms of a scale between 1 and 10, where would you say you are now?

What tells you that you are at 4 now? What else have you done to all the way up to 4?

What would it take for you to move up to 4.5? When you move up to 4.5, what would be different with your life?

Suppose I were to ask your best friend where she thinks you are at on the same scale of 1 to 10, what would she put you?

This time, 10 stands for how much you are willing to work to get your children back to live with you, and 1 stands for you're not lifting a finger to make it happen, where would you put yourself?

Suppose I ask your probation officer how motivated she believes you are, where would she put you on this scale? What would she do differently when she believes that you have moved up one point higher on the scale?

The variation and flexibility of use of scaling questions are limitless. They can be used

in a variety of therapeutic modalities, including individual, family and group settings. Many creative clinicians have adapted the scaling questions when working with young children or with clients who are described as developmentally challenged. For example, the clinician can draw a vertical line on a sheet of paper with the number 1 at the bottom and 10 at top and then ask the client to indicate their answer on this scale, or make use of a balloon and have a child indicate an answer, such as how scared they feel, by expanding or shrinking the size of the balloon.

### **RELATIONSHIP QUESTIONS**

Substance abusers affect other people around them; they are also affected by other people, especially their family members or best friends. Therefore, it is important that we bring the views of these important people into the conversation with a client because they can either undermine or support and reinforce the changes the client makes while in treatment. Further, any clinical suggestion for change must fit into the client's natural social context. In addition, these significant persons are potential resources for treatment because they are generally knowledgeable about the client's strengths as well as shortcomings. The following questions

show how the SFT approach includes the client's perception about their impact on others and help the practitioner obtain a richer view of the client's social network.

What do you suppose your children would say how close you've come to having them come home? What about your mother? Your best friend? What about the judge (probation officer)?

What would your daughter say that she likes best about you being sober when she visits with you?

Wow, you managed not to drink for a whole month!? How did you do this? You must worked very hard to achieve this. What would your mother (spouse/ best friend) say how you are different now that you've been sober for a whole month?

How confident would your mother say she is that you will stay clean this time, on a scale of 1 to 10, with 10 being that she is as confident as can be, and 1 the opposite?

What would your mother say how you are different now that you are working again, being stable and spending more time with your children and family? How is she different with you when she sees these positive changes your are making?

## COPING QUESTIONS

At times, practitioners may lose hope about a client and convey this feeling to the client, or a client may already reach a point where life seems hopeless to him or her. In such situations, *coping questions* are useful in eliciting strengths and internal resources of clients. When asked with compassion, curiosity, and admiration for the client's ability to "hang in there" in spite of what appears to be monumental odds against them, such questions can make the client more hopeful and become aware of the internal and external supports that are sustaining them. For example:

Most people would have a tough time getting out of bed when faced with such problems.

How did you manage to get out of the bed this morning?

Wow, you have lived through some tough situations, how do you keep going?

What keeps you going day in and day out in the middle of so many problems?

Most people in similar situations would have given up long time ago. How do you cope with such impossible circumstances day in and day out?

How come you are doing as well as you are doing, considering all the difficulties you have to cope with?

Where did you learn to be so strong, to keep going, to keep your family together?

For many mandated clients, being asked how they have coped with so many demands of the mandating systems or how they have the stamina and will to follow through on the many non-negotiable conditions forced on them generates much sense of pride and recognition of their successes. Such an approach enhances client motivation and their tenacious will to succeed, and strengthens their fortitude and determination not to give in to despair. It also points out their hidden resources that perhaps no one has recognized or given them credit for having.

### **MIRACLE QUESTIONS**

The *miracle question* is used to assist clients in generating a vision of life without their current problems. It helps clients consider possibilities they may have never thought of before thereby

shifting their whole belief system. Exploring the miracle question can provide a vision of a life that they have not dared to dream. The resulting new insight or belief often seems to transform the person.

The miracle question works best when asked in the following manner, in a slow, soft voice:

I am going to ask you a rather strange question. (Pause). Let's say that after we talk here today, you will do whatever you normally do for the rest of today. (Pause). Then tonight you go to bed and fall asleep. While you are sleeping, a miracle happens. And the miracle is that all the problems you have been telling me about that brought you here have been solved, just like that. (Snap your finger, long pause). But because you are sleeping, you have no idea that a miracle occurred. (Pause). So, when you are slowly coming out of your sleep, what will be the first, small sign that will let you know that the problem is all solved?

Frequently, even when using this carefully phrased sentencings, which is based on years of experimenting with different phrasings, the client is likely to say: "I don't know." However if the clinician waits patiently, the client slowly begins to formulate a reply, such as "Well . . . I suppose I would feel like I'm not hung over . . . I would want to get up and face the day, and not pull the cover over my head . . . Then I will go get some coffee . . . and not look for the bottle behind the couch." The clinician can then ask: "What would you do instead?" According to one client: "I will walk straight to the kitchen and get a glass of milk and a cup of coffee and sit down with a bowl of cereal." Another client, a mother of two who has been using cocaine for several years answered with, "I will get up in the morning and comb my daughter's hair." Since the significance of such ordinary act as "combing my daughter's hair" was lost on the clinician, the client was asked to clarify the significance of this miracle. The mother responded that this meant that she would not have used drugs the night before because when she does, she is unable to get up in the morning with the children to send them off to school. This vision becomes the first small step toward building an alternative solution to an existing problem.

## DEALING WITH RELAPSES

Relapse is a common phenomenon among substance abusers during the recovery process (Fisher & Harrison, 2000). When there is only a single criterion for success--such as total abstinence-- it increases the chances of failure, regardless of what problem one is trying to solve. However, instead of viewing relapse as a failure, it is more helpful to think that there has been some success, because without any successes there can be no relapse. It is also important to help the client see recovery as a process, so that each relapse episode does not compound a client's already discouraged and demoralized state of mind, leading to further discouragement. Because the client is already feeling ashamed, embarrassed, and guilty, it is not useful to reprimand him or her on another failure and get into the details of this failure. Instead, practitioners can use the following 5 steps to quickly help the client get back on the path to recovery:

**Step 1.** Approach the client who has recently relapsed with a positive mind-set and a genuine belief that tomorrow can be the beginning of a new future. As discussed earlier, most substance abusers have exceptions to their current problems, and it is those exceptions that need

to be focused on. Find out from the client how long it has been since the previous relapse. Then ask how the client managed to stay substance free for so long (for some, staying free of substance use for a day can be a huge success) and find out the details of what has worked for them. Many clients are surprised to find that they have forgotten about these small successes.

The following questions are very useful to expand on exceptions:

"How do you explain to yourself that you stayed clean for so many days?" "What do you suppose your family would say you did that was most helpful for you to stay clean, even for a day?"

"What would it take for you to be able to repeat this?"

"How confident are you that you can do this again?" If the client says for example that attending AA meetings was helpful in staying sober, ask what it would take him to return to AA meetings. This reminder of a successful period since the last relapse can be very encouraging to a client.

**Step 2.** Whenever you hear a report of a relapse from the client, ask the details of how he/she stopped when s/he did, instead of having clients recount how they started drinking again. Nothing can be gained by recounting the failure. What is important in building solutions is finding out what the client did successfully even in the midst of failure, such as making sure that the children were under the supervision of a babysitter and that they had enough food in the house. Also find out about specific cues the client picked up, either internally or from the environment that made him or her stop at 12 beers instead of continuing to drink the 13<sup>th</sup> one. The idea behind this approach is that if the client knows exactly what s/he did to stop at the 12<sup>th</sup> beer, then s/he can recognize they can stop at the 10<sup>th</sup>, 8<sup>th</sup>, or 5<sup>th</sup> drink, and so on. This shows the clients that they have some sense of control, which, however small, becomes a building block for the future.

**Step 3.** Clients rarely seek help in the midst of an active relapse, unless they are forcibly brought to a treatment center by police, family, or other health care workers. The majority of those who have relapsed usually show up at the treatment facility after they stopped using a

substance. It is helpful to find out what the person has done since s/he stopped drinking or doing drugs. For example, taking a shower, going back to work, apologized to the family and friends, returning to caring for the children, and so on. These are all solutions generated by clients, and need to be brought to their awareness so that they can repeat these useful strategies earlier next time. It is also important to elicit the perceptions of significant others by asking relationship questions such as, "What would your family say they liked the most about what you did first after you stopped drinking?" This line of questioning shifts the focus from the client to the family or other important people with whom the client may be interested in having a better relationship or in getting them "off my back."

**Step 4.** Find out what and how this current relapse is different from the last one.

Although the word "relapse" may imply that all relapses are the same, each relapse is different from the one before; this time they may have stopped sooner, used a little more or less alcohol or drugs, or did something different such as calling a sponsor sooner, asked for help from friends or family, or were less nasty toward her child. These small details can make a big difference during

the next relapse since they convey to clients that they have the power to make a difference, and what happens is not an accident.

**Step 5.** During this final step, it is helpful to discuss what are the lessons clients have learned from this relapse episode, and what concrete, detailed, behavioral, and measurable changes they will implement immediately into their daily life. What has she learned about her drinking (drugging)? What new information has he gained this time and what difference will this knowledge make in his life? How will others respond to her when her sobriety continues for a longer stretch of time? How will he take advantage of the next period of sobriety? What kind of lifestyle changes she will implement from now on? How exactly will she do this? What difference does he expect this will make in his life when this change continues a while?

Again, we find that when the practitioner is calm and hopeful about the client's future, and is always looking for a grain of successes in the midst of problems, the client can maintain hope for him or herself. Instilling such hope in clients is the greatest gift practitioners can offer.

Solution Focused Therapy with its "not-knowing" posture and the deep respect and appreciation for the client's unique perspectives and ways of doing things is highly congruent with our desire to honor and work within the client's cultural frame of reference. Regardless if it is a religious, cultural or ethnically driven remedy, if it valuable to clients, and if it works for them, we must have the humility to honor these approaches. It also means that our concept of what is defined as normative behaviors is much broader, while the concept of pathology is rarely discussed. The guiding framework has been clearly laid out by following three main principles:

1. If it works, don't fix it.
2. If it worked once, do it again.
3. If it doesn't work, don't do it again. Do something different.

## CONCLUSION

The guiding assumption of SFT has been greatly influenced by social constructionism and its view that what is real, what is viewed as acceptable behaviors, and host of other rules of conduct are all socially constructed. That is, the definition of psychopathology or mental health, of how much substance use is acceptable or not, under what condition, by whom and so on, are all socially negotiated. It is further understood that these negotiation takes place within the context of language since our primary tool is talking. It is easy to see how all clinical interventions are selective in their choice of what they ask about and what they ignore, and that this depends on the underlying assumptions about what is useful and helpful for their client. SFT believes that through talking we can trigger change, alter, and re-write our history, and create a different reality that is useful to clients as they navigate the world around them. How we look at an event influences what we see and what we believe, and this, in turn, influences what we do, and so on, in a domino like manner.

Taking responsibility for and focusing on "what works" or what is "different," or how one is changing contributes to different perspectives and beliefs about oneself. Guiding clients to participate in treatment by finding their own solutions, that is, finding what works for them, is not only respectful of his/her uniqueness, but also empowers them to view themselves as agents of change who can shape their own lives. This chapter has presented the guiding assumptions of SFT and offered some practical ways to help clinicians provide client-centered and more effective ways of working with individuals who are mandated into treatment.

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