

A Two-Day Workshop on Solution Focused Interviewing – A Report for LifeRing Convenors

On the Thursday and Friday leading up to the 2005 LifeRing Congress in Guelph, Dr. Ronald Warner of the University of Toronto led a workshop entitled “Solution Focused Interviewing: Basic Skills.” I was one of the more than two dozen paying participants.

Like Moliere’s bourgeois gentleman who discovers that he has been “speaking prose all his life,” I came away from the workshop with the feeling that I have been practicing Solution Focused Therapy for years without knowing it. Solution Focused Therapy and its abbreviated version, Solution Focused Interviewing, have so much in common philosophically and practically with my understanding of the LifeRing approach that I found myself nodding frequently during Dr. Warner’s presentation, and sometimes felt that I could finish his sentences.

SFT came originally out of Milwaukee, where the Korean-born therapist Insoo Kim Berg and her husband Steve de Shazer and others developed the [Solution Focused Model](#) in the 1980s. Practitioners can now be found all over North America and Europe. Dr. Warner is the chief Canadian advocate of the trend; he has been teaching SFT at various universities in Canada for more than a decade and is head of the SFT certification panel for Canada.

Dr. Warner distributed a 12-page handout in advance of the two-day workshop, and I am going to borrow liberally from this paper in my discussion here. It may be best to begin with three of the basic assumptions from which SFT starts. The congruency with the LifeRing convenor’s approach will be most obvious.

1. *Accentuate the positive.* For SFT, this is the core of the whole approach. Focus on what is wanted, rather than on what is wrong; build on strengths rather than dwelling on weaknesses; work toward empowerment. Isn’t this what LifeRing does also? We see the “S” in each person; we build on that inherent strength; we encourage people to see their positive achievements rather than beat themselves up for their weaknesses; we make empowerment of the sober self our guiding principle.
2. The SFT practitioner is not the expert; the *client is the expert* on what will work for them. The practitioner does not make diagnoses and does not prescribe solutions. The practitioner merely facilitates healing that occurs naturally in people’s lives, if given a chance. – Isn’t that a valid description of the LifeRing convenor’s role? In Ch. 2 of *How Was Your Week* I described the LifeRing convenor in essentially similar terms. As LifeRing convenors, we have a profound respect for our fellow recovering people as practical scientists who can and will discover the road they need to take, if given support, encouragement, and a choice of tools. That respect is the basis of our self-help philosophy.
3. The SFT practitioner’s expertise is in the *solution-building process*. The practitioner’s skills consist not in a set of solutions or diagnoses, but in a set of tools for guiding the client’s focus inward toward strengths and outward toward the

positive solutions in the future. Similarly, the LifeRing convenor's expertise consists of a set of tools that guide the process of the meeting toward connections, strengths, and solutions.

Although these points seem almost obvious and uncontroversial, Dr. Warner pointed out that they involve a radical paradigm shift from the assumptions of traditional psychoanalysis and its progeny. In psychoanalysis, generally speaking, the client is led to focus on problems and weaknesses, and the main path of inquiry is backward in time, toward presumed hurtful episodes during early childhood. The traditional approach assumes that a solution follows from an exploration of the problem. SFT asserts, by contrast, that exploring the problem may actually re-traumatize the client and lead further away from a solution. The cause of the problem often can only be seen in its true light after the client has moved securely forward into the solution. It would have been interesting to explore these conflicting historical paradigms further, but Dr. Warner – consistent with his teaching – moved our discussion forward.

The SFT practitioner's interaction with a client, Dr. Warner taught, moves in three general stages.

(1) In the first stage, the practitioner establishes empathy with the client. On this point, Dr. Warner assumed that the workshop participants – mostly treatment professionals with various mental health and substance abuse agencies -- were somewhat familiar with the psychological literature on establishing empathy, and therefore did not go into much detail. Generally speaking, the practitioner's goal is to validate the client's feelings, both positive and negative. But the practitioner merely accepts and acknowledges "problem talk" (negative content) without expanding or exploring these aspects. By contrast, the practitioner accepts, acknowledges, and also compliments and explores/expands on the client's strengths and resources (positive content).

(2) After establishing rapport, the practitioner begins to elicit the client's positive goals. The client is asked to define desired changes in behavioral, manageable, and positive terms. Typical questions are: "What would you like to be doing instead?" "What do you want to have happen?" "How will you know when things are better for you?" "How do you know that you can move toward these goals?"

(3) Finally, after developing empathy and eliciting the client's goals, the SFT practitioner unwraps the core SFT toolkit of five sets of questions designed to get the client working toward a self-defined solution, and to build empowerment. The five issues that the questions address are:

1. Find Exceptions. Are there exceptions to the problem? Are there times when the problem does not appear, or when it is less serious? What are the circumstances surrounding those times? How can those exceptional times be recreated and enlarged upon? How can we magnify the positive exceptions so as to overcome the negative rule?

2. **Visualize Outcome.** Envision how life will be different when the problem is solved. Specify the differences in as much concrete detail as possible. Imagine that by some miracle the problem went away one morning. How would you know that it was gone? What specific changes will have occurred?
3. **Define Doable Progress.** Estimate the severity of the problem right now on a scale of 1-10. Ask the client what it would take to move one half step closer to the solution. Look for small, specific, manageable goals.
4. **Get Other Perspectives.** Ask the client how other people in their life would view the situation. How would other relevant people respond to even a small movement by the client toward a solution?
5. **Elicit Strengths.** Elicit the client's survival and coping skills. How did you manage to cope with this problem as well as you have done? How have you managed to survive despite these problems? These questions are designed to build confidence and elicit inner strengths.

The gist of these five questions is to move the client into “solution talk,” that is, to focus on inner strength and resources, to define achievable positive goals, and to mobilize the client's motivation to employ the inner strengths in the service of progress. The SFT practitioner is taught to compliment the client for their strengths and achievements, no matter how small. When used skillfully, this approach can lead clients to commence important and enduring changes in their lives in a relatively short time. Unlike psychoanalysis, which frequently requires several years of therapy, SFT is designed to move the client from contemplation to action in a short period of time – one or two interviews, for example. Many SFT practitioners now use the abbreviation SFBT for their craft – [Solution-Focused Brief Therapy](#).

Much of Dr. Warner's two-day workshop developed these main points in considerable detail. There is an extensive SF literature addressing a broad range of particular issues, such as working with prisoners, with childhood trauma survivors, with families, etc. There is even some SF literature on addiction, which I hope to read one of these days. Those who wish to pursue it further may want to obtain an SFT credential. What I came away with from the workshop was two main points:

One, that our general approach – in terms of accentuating the positive, looking for strengths, working for empowerment – was understood and accepted by SFT practitioners. Empathy, of course, is basic to our peer leadership system. Trusting in meeting participants' expertise to solve their own problem – rather than asking convenors to develop solutions for other participants – is basic to our self-help, small-p program building philosophy. Similarly, the concept of eliciting the client's own goals, rather than imposing a life-path template, is at the core of the LifeRing approach. We came to this approach empirically, by trial and error, almost blindly, and it feels reinforcing to see that others independently came to similar conclusions, and that there is a considerable body of theory and research to back it up. SFT people look like excellent partners in dialogue for us.

Secondly, I came away feeling that many of the specific methods that SFT practitioners use are or ought to be in most convenors' toolkits. For example, how often have we seen people who complain that they have cravings to drink or use all day long? But if we ask about exceptions – “is there ever a moment during the day when you don't have a craving?” – we will usually find some time when they feel empowered not to drink or use. If they can learn to take positive action during this brief opening (for example, enroll in treatment, go to a meeting, or some other sober-empowering activity) then they can in a relatively short time come to a new equilibrium where cravings are the exception and freedom from cravings is the rule.

SFT's second question, visualizing the solution, is a very powerful tool. In LifeRing meetings in the closed acute crisis psychiatric ward at a local hospital, I frequently use a variation on this theme. I remind the patients of Dr. Martin Luther King's “I Have a Dream” speech, and ask them if they have a dream about themselves as clean and sober persons. These discussions often uncover the patients' strengths and resources, and leave them visibly fortified. Their posture is more upright, they speak more clearly, they walk more firmly; and clinical staff has noticed this also, as witness the [letter of recommendation](#) they gave us.

SFT's third question set – scaling – points to the importance of defining small, achievable, positive steps that the client can take immediately. Our “How Was Your Week?” meeting format excels at eliciting these kinds of real-scale everyday successes. A convenor listening to a meeting participant who voices feelings of powerlessness might well ask the person what they could do to move just one inch toward the edge of the morass in which they feel themselves drowning.

Asking about relationships – SFT's fourth question set – is a good tool for the convenor who is facing a person who blames everyone else but themselves. “How do you think [your spouse] views what you are doing now?” This is a useful technique for bridging antagonisms and moving people toward a compromise.

The fifth SFT question set – “coping” -- is something I have often seen LifeRing convenors use. When someone is beating themselves up, typically over a relapse, the convenor doesn't agree with them that they were stupid or morally rotten. Instead, the convenor congratulates them for cutting the relapse short and getting back into recovery. “That shows a lot of strength, to stop drinking and come back here, good for you!” is what most LifeRing convenors would say, and this is exactly what SFT practitioners would also do. Eliciting people's strengths and highlighting their resources is basic LifeRing stuff – it's all part of empowering your sober self.

Outcome studies suggests that the classic problem-focused approach, psychoanalysis, has virtually zero potency with substance addictions. (See the Lowinson volume, and the Hester-Miller study, both on unhooked.com.) So long as a patient is drinking/using, they probably cannot go very far in psychoanalysis to begin with, and even if they could discover “why I drink,” this knowledge would not empower them to stop. Focusing on the solution – a fully engaged life free of alcohol and drugs – has to be the priority. They will have time for

psychoanalysis once they are sober, if they still want to go there. Much anecdotal evidence from 12-step followers relapsing on the fourth and fifth steps supports Dr. Warner's thesis that focusing on weaknesses and revisiting the past can retraumatize the patient and add to their burdens. The recital of "war stories," a classic case of dwelling in the problem, tends to trigger the audience and to strengthen their addictive responses.

Several times since Dr. Warner's workshop I found myself avoiding the temptation to engage in finger-pointing exercises (dwelling in the problem) so as to focus on finding a way forward. There is not only good therapy in this approach, there is a lot of wisdom for a broad range of life situations.

Of course, LifeRing is never going to be reduced to a single therapeutic approach. The Sober-to-Sober supportive interaction that is the engine of the LifeRing process vitally depends on the freedom to go wherever sober thoughts and feelings will go. Multiplicity, diversity, choice are the watchwords, including in the realm of trends in psychology. I have had the same nodding-in-agreement experience when reading about Motivational Interviewing, when reading some of the works of Carl Rogers, and quite a few other writers. LifeRing will always be inclusive of all abstinent approaches and trends in psychology. Still, given the remarkable areas of congruence that I discovered in Dr. Warner's workshop, I feel that SFT is definitely an approach that LifeRing convenors will want to know about and make part of their toolkit.

-- Marty N. 5/14/05