SOLUTION-BASED BASICS

Possibilities, 223 N. Guadalupe #278, Santa Fe, NM 87501 USA, 505.983.2843, fax 505.983.2761, website: www.billohanlon.com; email: PossiBill@aol.com

Other websites of Bill’s to check out if you are curious:
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PHILOSOPHY
AND ASSUMPTIONS
OF
SOLUTION-BASED THERAPY
#### DISCOURAGING VS. POSSIBILITY THERAPY

**EXPLANATORY STYLES**

Bill O’Hanlon, M.S., Possibilities, 223 N. Guadalupe #278, Santa Fe, NM 87501 USA

www.billohanlon.com; email: PossiBill@aol.com

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<th>Discouraging Therapy</th>
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<th>Possibility Therapy</th>
<th>Examples</th>
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<tr>
<td><strong>Permanence of Problems</strong></td>
<td>Problems are persistent and lasting</td>
<td>It took a long time to develop this problem, so it will take a long time to resolve it.</td>
<td>Problems are temporary and changeable</td>
<td>So far you haven’t found a way through this problem.</td>
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<tr>
<td><strong>Globalization of Problems</strong></td>
<td>Problems are pervasive and occur throughout the person’s life, although they may be masked in some circumstances</td>
<td>This symptom is just a manifestation of some deeper, underlying problem.</td>
<td>Problems do not happen all the time and everywhere; there are always exceptions</td>
<td>You said you have felt like killing yourself all month and yet last night was the first time you acted on that.</td>
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<tr>
<td><strong>Identification with Problem</strong></td>
<td>The person is the problem</td>
<td>He is a perpetrator; she is a borderline</td>
<td>The problem is the problem, the person does, is influenced by or experiences the problem</td>
<td>He molested a child; she is hallucinating. Temper tantrums have been running the show, huh?</td>
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<tr>
<td><strong>Determinism vs. Accountability</strong></td>
<td>The past or the person or the person’s family cause the problem and/or created certain unchangeable qualities in the person. The person is determined by his/her past, personality, genetics, family background, etc.</td>
<td>It seems to me that your parents were so needy that they couldn’t fulfill your needs and that’s why you have developed this problem.</td>
<td>Causes are complex and uncertain, so the focus is on what to do to change the situation in the present and the future</td>
<td>So you came from a dysfunctional family and that goes a long way towards explaining why you have your current problems, but the more pressing issue is what you can do about the problems now.</td>
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People are influenced by, and not determined by, the past.

People are influenced by their sense of what is possible for their future.

People are influenced by their thoughts and feelings, but their actions and the course of their lives are not necessarily determined by either.

At any moment, unless physically compelled by someone who holds power over them or unless they are prevented by physical incapacitation, people can choose what action to take.

People are more likely to cooperate when they and their feelings and points of view are validated and respected.

We therapists can never know the truth about people because we are always influencing what aspects of that truth get spoken and heard.

No one knows for certain what causes behavioral, psychological, emotional or relational problems (although there is no shortage of people who will claim to know).

What we do in therapy either works or it doesn’t. If it doesn’t work, it’s best to first try something different rather than deciding the person, couple or family is unmotivated or unable to change.

There are many pathways to change. No one technique, method or philosophy works for everyone, although again, there are no shortage of people who will tell you they know the one right and effective way to help people change.

What helps create change is not necessarily an indication of what caused the problem.
CONTRASTING TRADITIONAL THERAPY TO SOLUTION-BASED APPROACHES
Bill O’Hanlon, M.S., Possibilities, 223 N. Guadalupe #278, Santa Fe, NM 87501
505.983.2843; PossiBill@aol.com; http://www.billohanlon.com

Impairment/deficit---------------------------->Competence/ability
Pathology---------------------------------->Health
Bad/hidden agendas/resistance-------------->Good intentions/cooperation
Cure-------------------------------------->Consultation/small changes
Authoritarian/colonization------------------>Collaboration/shared expertise
Working through/working on/insight-------->Goal/results
Past focus---------------------------------->Present/future orientation
Expression of emotion---------------------->Validation of felt experience
Diagnose stuckness------------------------>Change orientation
Identity/personality problems/structure -->Action/process descriptions
NEW POSSIBILITIES FOR THERAPEUTIC CONVERSATIONS

Traditional conversations therapists have:
Conversations for true explanations
  Searching for evidence of functions for problems (the functions attributed may be either benevolent or malevolent)
  Searching for or encouraging searches for causes and giving or supporting messages about determinism (biological/developmental/psychological)
  Focusing on history as the most relevant part of the person’s life
  Engaging in conversations for determining diagnosis, categorization, and characterization
  Supporting or encouraging conversations for identifying pathology
Conversations for inability
Conversations for insight/understanding
Conversations for expression of emotion
  Eliciting clients’ expressions of feelings and focusing on expression of feelings
Conversations for blame and recrimination
  Attributions of bad personality traits or bad intentions
Adversarial conversations
  The therapist believes clients have hidden agendas that keep them from cooperating with treatment goals/methods
  Using trickery/deceit to get the client to change
  The therapist is the expert and clients are non-experts

The new tradition:
Collaborative conversations
  Clients and therapists are partners in the change process
  Clients are experts in teaching the therapists about what they are experiencing, have experienced, what they want and what fits for them
Conversations for change/difference
  Highlighting changes that have occurred in clients’ problem situations
  Presuming change will happen and is happening
  Searching for descriptions of differences in the problem situation
  Introducing new distinctions or highlighting client distinctions
Conversations for competence/abilities
  Presuming client competence/ability
  Searching for contexts of competence away from the problem situation
  Eliciting descriptions of exceptions to the problem or times when clients dealt with the problem situation in a way they liked
Conversations for possibilities
  Focusing the conversation on the possibilities of the future/goals/visions
  Introducing new possibilities for doing/viewing into the problem situation
Conversations for goals/results
  Focusing on how clients will know that they have achieved their therapeutic goals
Conversations for accountability/personal agency
  Holding clients/others accountable for their actions
  Presuming actions derive from clients' intentions/selves
Conversations for actions/description
  Channeling the conversation about the problem situation into action descriptions
  Changing characterizational/theoretical talk into descriptive words
  Focusing on actions clients can take that can make a difference in the problem situation
METHODS OF SOLUTION-BASED THERAPY
TYPES OF QUESTIONS AND STATEMENTS
IN SOLUTION-BASED THERAPY
Bill O’Hanlon, M.S., Possibilities, 223 N. Guadalupe #278, Santa Fe, NM 87501
505.983.2843; PossiBill@aol.com; http://www.billohanlon.com

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

Example: On a scale of one to a hundred, one hundred being no depression and one being the most depressed you could be, where have you been in the past week?
Example: What would it take to get you to have a ‘seven’ week instead of the ‘six’ week you had last week?

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

Example: So was that different from the way you have usually handled it?
Example: So his asking questions was different from his typical mode of making accusations?

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

Example: How did you manage to stop bingeing?
Example: How did you do that?

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

Example: How will you know when therapy is successful and we can end?
Example: What will you be doing after therapy? How will others know you've changed?

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

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

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

Example: Can you recall a time when you thought you would binge, but instead you resisted the urge?
Example: Can you tell me about a time when John was able to sit quietly and surprised you or himself?

Description Questions
Asking the person or the family to describe the problem or solution situation in observable terms.

Example: How did you manage to stop bingeing?
Example: How did you know that he was having a better day? What would I have seen on a videotape on that day?
Example: How would I know he was doing something you call passive-aggressive?
<table>
<thead>
<tr>
<th><strong>Smaller Step Questions/Comments</strong></th>
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<tbody>
<tr>
<td>Designed to get people to scale back their grand ideas about their goals or progress into more achievable ends or progress.</td>
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<tr>
<td>Example: That sounds like a big goal and dream. What kinds of things would be happening in the next week if you were headed in the direction of those big dreams?</td>
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<td>Example: What is the first sign you would see that you were doing what you needed to do to get over your depression?</td>
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<tr>
<th><strong>Highlighting Change/New Stories</strong></th>
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<tr>
<td>Designed to get people to notice or acknowledge changes or differences in their perceptions of themselves or other people’s views of them.</td>
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<tr>
<td>Example: What do you think your friends would think about you since you have come to think of yourself as able to stand up for yourself?</td>
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<tr>
<td>Example: What effect does knowing that you’re resolved not to cut yourself anymore have upon your view of yourself?</td>
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<tr>
<th><strong>Motivation Questions</strong></th>
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<tr>
<td>Designed to assess people’s motivation to change and to determine whether you have a “customer” for change.</td>
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<td>Example: Do you want to change anything or is it just a concern of your parents?</td>
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<tr>
<td>Example: On a scale of one to ten, how eager are you to change this situation right now?</td>
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For the client

- How will we know when it’s time for you to leave therapy, when we’ve been successful? [Ask for a video description or get a scaling estimate.]
- What happened that gave you or whoever thought you should be here the idea that therapy would be the best place to sort out the difficulty (difficulties)?
- After you finish coming here, what kind of changes do you think you’ll make in your life?
- What’s the first sign you’ll be able to notice that therapy had been helpful to you?
- What’s the first sign others will be able to see when you start (feel better; get better; feel more hopeful; really know you want to live; etc.)?
- If you’ve experienced a similar difficulty before, how’d you deal with it?
- How about one of the times when the difficulty started to develop, but you stopped it before it went too far? [If they don’t report any positive coping experience, reply, “So you can't remember any time like that right now.”]
- What was the high point of the last year for you?
- Can you remember a time recently when you pleasantly surprised yourself or did something out of character that pleased you?
- What medications or therapy approaches have worked best for you, if any?
- What hobbies or interests do you have or have you had in the past? What was interesting or valuable about those activities?
- What kind of work do you do or have you done?
- (For adolescent) What was/is your favorite subject or class in school? Why?
- (For adolescent) What was/is your favorite music or song? Why?
- (For reports of previously overcome problems) You told me you used to use drugs or alcohol and then stopped. How did you do that? or You told me you were suicidal last fall. How did you get through that time without harming yourself or doing yourself in?

For the referral source/family member

- What gives you the idea that the person needs to be in treatment?
- Who has been most upset or vocal about the client’s behavior?
- How will you know that treatment has been successful and that I have done a good job? [Get a video description.]
- What has been the most pleasantly surprising thing you’ve seen or heard from or about the client recently?
- What would you like me to do to keep you informed on the client’s progress or to keep getting your input?
SETTING ACHIEVABLE GOALS IN THERAPY

Bill O’Hanlon, M.S., Possibilities, 223 N. Guadalupe #278, Santa Fe, NM 87501
505.983.2843; PossiBill@aol.com; http://www.billohanlon.com

Achievable goals consist of clients’ actions or conditions that can be brought about by clients' actions. Often they include time elements: how often (frequency); when (date/time/deadline); and, how long (duration). Define the goal in terms of final resolution of the therapy concern or of enough progress to terminate or take a break from therapy.

The goal must be mutual. If there is more than one client, or the customer (the person who initiated therapy and is motivated to make things change) is not the client, all parties must agree that the goal is relevant and achievable.

Translate vague, non-sensory-based words and phrases into action-based language. Goals are more checkable if clients state them as if they could be viewed/heard on a videotape player. Find outer (observable) correlates for feelings and inner states/qualities. Sometimes quantifying inner experiences or qualities by rating them on a scale is helpful. Then find action steps the client could do that would improve the rating to the desired level.

Example: On a scale of 1 to 10, where would you rate your current or recent feelings of self-esteem and where will it be on that scale when you have reached your therapy goal successfully?

Provide multiple choice answers when clients hesitate in stating clear goals or when they continue to answer your queries about their goals with vague words and phrases.

Sometimes it is important to inform clients that you are searching for an achievable goal and give them a rationale for your search.

Example: I keep going back to this issue of how we'll know when we've been successful and can stop meeting because I want to make sure we're working on your goals, not mine.

OR: I get concerned that what we're doing in here could become (or has become) part of the problem instead of the solution. I think defining a goal will help avoid that because we'll have a clearly defined stopping place.

OR: Sometimes therapy becomes a slippery business. It's like nailing jello to a tree. It can be discouraging wondering whether I'm really helping people change or just passing the time. So it would help me to pin down a specific goal.

Focus on the goal and a successful outcome as early as you can without alienating the client. If you are getting messages that the client is irritated with the focus on goals, either explain your purpose or back off and refocus on what they are indicating is more important to discuss.

Example: This may seem a funny place to start, but I always like to know where I'm going, so I can listen better for what will be helpful to you. So, if you can, tell me what you hope will be happening in your life when we've been successful in here. What will you be doing after therapy? How will others know you've changed? How will you know? And if you can, I'd like to hear it in a way that I can imagine seeing on a videotape.

Assume that therapy will be successful. Use words like “will,” “when,” and “yet,” when speaking about the clients therapy (or post-therapy) goals.

Example: So you haven't asked a woman out for a date yet and you'd like to be able to get into a relationship?

Example: When you're feeling better, less depressed or not depressed, you'll be getting up earlier and spending more time with friends?
IDENTIFYING AND ELICITING MOTIVATION TO CHANGE
Bill O’Hanlon, M.S., Possibilities, 223 N. Guadalupe #278, Santa Fe, NM 87501
505.983.2843; PossiBill@aol.com; http://www.billohanlon.com

THE SIX TYPES OF MOTIVATIONS FOR CHANGE

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<th>Negative past motivation</th>
<th>Positive past motivation</th>
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<td>Negative present motivation</td>
<td>Positive present motivation</td>
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<tr>
<td>Negative future motivation</td>
<td>Positive future motivation</td>
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Here are some questions to ask clients to identify and elicit motivation:

- What did you dislike in your past that you want to make sure does not happen again?
- What happened to you that you are adamant should never happen to others?
- What wound did you suffer that sensitizes you to others’ similar pain or suffering? What might that sensitivity lead you to do to use it in a productive way?
- What aspect of your life in the past are you longing to recreate or stay connected to?
- About what are you so uncomfortable at the moment that you are motivated to change it?
- What would you most like to change in your life or situation right now?
- If what’s bothering you right now were resolved, how would your life change?
- If your fondest dreams came true, where would you be and what would be doing in a year? Five years? Ten years? [Or choose an appropriate time frame]
- If things continued as they are going, what would be happening in a year and how would that be for you? Five years? Ten years? [Or choose an appropriate time frame]

**Motivation 101: A summary**

- You need to have energy, motivation, to change
- There are two types of motivation, things you want to get away from and thing you want to go toward
- Identify which of these motivations is relevant for your clients
- If the person you are seeing is not motivated (a rarity—they are often at least motivated to stop seeing you or avoid legal consequences), find out who is motivated in the situation and tap into them for change
- Link the identified motivation to the desired change
It’s important for therapists to know what they are being asked to accomplish and to clarify the goal of the person or people who are asking for help. This is what I call developing a focus. This focus takes into account the multiple customers/complainants with different agendas. If it is not mutual and all parties do not agree on what constitutes a successful outcome, there may be trouble. Here are some questions and guidelines to help clarify this crucial issue in therapy.

**The Complaint(s)-What is bothering someone enough to get them to seek or get sent to treatment?**

- Who is complaining?
- Who is alarmed about something?
- What are they complaining or alarmed about?
- Translate vague and blaming words into action descriptions (videotalk).
- When has the complaint typically occurred?
- Where has the complaint typically occurred?
- What are the patterns surrounding or involved in the complaint?
- How does the person, the customer, or others involved in the situation explain the complaint?

**The Customer(s)/Complainant-Who is willing to pay for therapy and/or do something to effect change? Whose concerns will constrain or affect therapy? Who is pushing for change?**

- Who is paying you?
- Who is complaining the most?
- Who will be able to terminate therapy?
- What are the legal and ethical restraints or considerations (suicidal plans/attempts, homicidal & violence plans/history, court/legal involvement, etc.)?

**The Goal(s)–How will the client(s) or customer(s) know when therapy has been helpful enough to terminate or when the agreed upon results have been achieved?**

- What are the first signs that will indicate (or already have indicated) progress towards the goal(s)?
- What are the final actions or results (again in videotalk–seeable, hearable, checkable if possible) that will indicate that this is no longer a problem?
- How will we know when therapy is done, when it has been successful?
- Get goal description in video terms. Translate labels or theoretical concepts into action descriptions if possible. If not, get the client to rate the subjective experience of the problem on a scale and select a target number for success on that scale.

Take the complaints, the customers/complainants and the goals into consideration when finding a focus for therapy. Develop a mutually agreeable goal and then focus on attaining that goal with your interventions. Do not let therapy stray too far afield from the focus and always check new information and ideas for relevance to the focus.
It is important to both acknowledge and validate clients without closing down the possibilities for change for them. Too much emphasis on change and possibility can give clients the message that the therapist does not understand or care about their suffering or dilemmas. Too much emphasis on the acknowledgment side can give the message that the client cannot change or might encourage wallowing in the pain and hopelessness. The following methods are designed to combine both acknowledgment and invitations to change and possibility. Remember that these are methods and if they start to become formulaic, they can be used disrespectfully or superficially. They are designed, however, to be respectful and to deeply empathize with clients’ suffering and possibilities.

**Method #1  Spinning Problems into the Past**

Use the past tense when people speak about current problems or limitations.

- **Statement:** “I’m constantly suicidal.”
  **Your response:** So you’ve really been suicidal.

- **Statement:** “I can’t do anything right.”
  **Your response:** You haven’t done anything right.

**Method #2  Going Unglobal**

Respond to generalized statements by restating them with slight changes in the quantifiers and qualifiers.

- **Statement:** “Nobody listens.”
  **Your response:** It’s been close to impossible to get people to listen.

- **Statement:** “I always leave everything ‘til the last minute.”
  **Your response:** Most of the time you leave things ‘til the last minute.

**Method #3  Spinning Reality/Truth Claims into Perceptions**

Limitations are often less in reality than in peoples’ perceptions. Reflect limitation statements by inserting perception phrases into them.

- **Statement:** “I won’t be able to keep a relationship going.”
  **Your response:** You don’t think you’ll be able to keep a relationship going.

- **Statement** “He’ll never change.”
  **Your response:** Your sense is that he really can’t change.
PROBLEMS INTO PREFERENCES:
A FUTURE-ORIENTED ACKNOWLEDGMENT METHOD
Bill O’Hanlon, M.S., Possibilities, 223 N. Guadalupe #278, Santa Fe, NM 87501 USA
www.billohanlon.com; email: PossiBill@aol.com

When people first seek therapy, they are often focused on the past and what isn’t working. How does the therapist gently and respectfully invite them into the future without minimizing their suffering or invalidating them? I use a method that owes a lot to both Carl Rogers (for the acknowledgment and reflection of people’s experience and feelings) and Milton Erickson (for the indirect shifting of attention and frame of reference). This method helps people re-orient their attention from what they cannot change (the past) and what hasn’t been working (the complaint) to what they can change (the future) and what they would prefer to have happen (their goal or direction or desire). If done respectfully and skillfully, most people do not even notice the shift consciously, but many report feeling more hopeful after it is used through the interview.

• **Rephrase from what is unwanted to what is desired or preferred**

  *Client:* I think I’m just too shy to find a relationship. I’m afraid of women and being rejected.
  *Therapist:* So you’d like be more comfortable around women and to be able to get into a relationship.

• **Redirect from the past or present to the future**

  *Client:* We argue all the time.
  *Therapist:* So you’d like to be able to work out conflicts without having so many arguments and even to have fewer conflicts if possible.

• **Mention the presence of something rather than the absence of something**

  *Client:* He never does anything we ask him to.
  *Therapist:* You’d like to see some cooperation from him.

• **Suggest small increments rather than big leaps**

  *Client:* I can’t stand this depression.
  *Therapist:* You’d really like to find some way to feel a bit better and be a bit less depressed.
Questions to Open Collaboration in Therapy
Bill O’Hanlon, M.S., Possibilities, 223 N. Guadalupe #278, Santa Fe, NM 87501 USA
www.billohanlon.com; email: PossiBill@aol.com

What are you concerned or worried about?
What would you like to have happen here?
What has been working so far?
What has been frustrating or difficult in the situation up to now?
How have you dealt with that frustration or difficulty at your best moments?
At your worst moments?
If you could do one small thing that might make a difference, what would that be?
How will you know that things are heading in a good or better direction?
How will you know when the situation is resolved? Or at least better enough?
If you met someone else with the same or similar issue, what advice or compassion would you offer them?

Here’s what I am concerned about.
I don’t understand this part.
I think this is what you’re saying. Is that right?
Is there anything you would like me to understand that you are not sure I have so far?
What would let you know that I have really understood what you are going through and have given it enough weight?
Is this conversation helpful or going in the right direction?
**FOUR PLACES FOR INTERVENTION IN THERAPY**

Bill O’Hanlon, M.S., Possibilities, 223 N. Guadalupe #278, Santa Fe, NM 87501 USA  
www.billohanlon.com; email: PossiBill@aol.com

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<th>BEING</th>
<th>VIEWING</th>
<th>DOING</th>
<th>CONTEXT</th>
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<tbody>
<tr>
<td>❖ Feelings</td>
<td>❖ Points of views</td>
<td>❖ Action patterns</td>
<td>❖ Community (church, neighborhood, clubs)</td>
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<tr>
<td>❖ Sense of self</td>
<td>❖ Attentional patterns</td>
<td>❖ Interactional patterns</td>
<td>❖ Social relationships (friends, non-nuclear relatives, teachers, mentors, neighbors, role models/heroes)</td>
</tr>
<tr>
<td>❖ Bodily sensations</td>
<td>❖ Interpretations</td>
<td>❖ Language patterns</td>
<td>❖ Physical environment/spatial location</td>
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<tr>
<td>❖ Sensory experience</td>
<td>❖ Explanations</td>
<td>❖ Nonverbal patterns</td>
<td>❖ Cultural/racial background and propensities</td>
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<tr>
<td>❖ Automatic fantasies</td>
<td>❖ Evaluations</td>
<td>❖ Time patterns</td>
<td>❖ Family/historical background and propensities</td>
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<tr>
<td>and thoughts</td>
<td>❖ Assumptions</td>
<td></td>
<td>❖ Biochemical/genetic background and propensities</td>
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<td>❖ Imagery and intuition</td>
<td>❖ Beliefs</td>
<td></td>
<td>❖ Gender training and propensities</td>
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<td></td>
<td>❖ Identity stories</td>
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<td>❖ Spirituality</td>
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Give messages of acceptance, validation and acknowledgment. There is no need to change or analyze experience as it is not inherently a problem.

Challenge problem views that:
❖ **Blame**  
❖ **Impossibility**  
❖ **Invalidation**  
❖ **Non-accountability**.

Offer new possibilities for attention.

Find patterns that are part of the problem and that are the “same damn thing over and over.” Then suggest disrupting the problematic patterns or use solution patterns.

Suggest shifts in the context around the problem (e.g. changes in biochemistry, time, space, cultural habits and influences, etc.) Use these areas to normalize (and therefore value and validate).

First, acknowledge and validate clients’ experience and sense of themselves as okay (if you don’t do that, they probably won’t be available to change). Then, when working on change, focus on the three other columns: Changing the viewing, changing the doing and changing the context. There are typically two ways to change these areas. One is to find out what hasn’t been working or is problematic in these areas and shift clients out of those unworkable patterns. The other is to find out what works, has worked or that clients would imagine would work in these areas and encourage clients to increase the workable patterns.
INVESTIGATING HOW PEOPLE “DO” THEIR PROBLEMS
Bill O’Hanlon, M.S., Possibilities, 223 N. Guadalupe #278, Santa Fe, NM 87501 USA
www.billohanlon.com; email: PossiBill@aol.com

➢ Get people to teach you how you could reproduce the problem if you tried to create it.
  Example: If I were going to gain weight, as you said you have, how would I go about it?
  Example: Teach me your method for doing depression.

➢ Get details of the thoughts, feelings, sensations, fantasies, actions, interactions and contexts when the problem typically happens.
  Example: Tell me what kind of thoughts go through your mind just before you make yourself vomit.
  Example: What do you notice in your experience as you are getting anxious?

1. If you had control of all the body’s physiological functions, how would you create this problem?
   Example: If I were going to do a good anxiety attack, I would increase the body’s heart rate and increase sweating in the hands.
   Example: If I were going to create impotence, I would decrease the blood flow to the genitals.

➢ How would the person make the problem worse or better, if they could?
  Example: If I was going to learn how to make the insomnia even worse than it is, what would I have to do if I were you?
  Example: Is there anything you have done that seems to help you go to sleep and stay asleep?
The idea is not to convince clients that they have solutions and competence, but to ask questions and gather information in a way that convinces you and highlights for them that they do.

1. Ask clients to detail times when they haven’t experienced their problems when they expected they would
   ❖ Exceptions to the rule of the problem
   ❖ Interruptions to the pattern
   ❖ Contexts in which the problem would not occur (e.g. work, in a restaurant, etc.)

2. Find out what happens as the problem ends or starts to end
   ❖ What is the first sign the client can tell the problem is going away or subsiding?
   ❖ What has the person’s friends/family/co-workers, etc. noticed when the problem has subsided or started to subside?
   ❖ What will the person be doing when their problem has ended or subsided different from what he or she is doing when the problem is happening or present?
   ❖ Is there anything the person or significant others have noticed that helps the problem subside more quickly?

3. Find evidence of choice in regard to the problem
   ❖ Determine variations in the person’s reactions or handling of the problem when it arises. Are there times when he or she is less dominated by it or have a different/better reaction to it or way of handling it than at other times?
   ❖ Have the person teach you about moments of choice within the problem pattern.

4. Resurrect or highlight alternate identity stories that don’t fit with the view that the person is the problem
   ❖ Find out from the person (or from his or her intimates) about times when the person has acted in a way that pleasantly surprised them and didn’t generally fit with the view that the person is the problem.
   ❖ Get the person (or intimates) to trace back some evidence from the past that would explain how or why the person has been able to act in a way that doesn’t fit with the problem identity.

5. Search for other contexts of competence
   ❖ Find out about areas in the person’s life that he or she feels good about, including hobbies, areas of specialized knowledge or well-developed skills, and what other people would say are the person’s best points.
   ❖ Find out about times when the person or someone he or she knows has faced a similar problem and resolved it in a way that he or she liked.

6. Ask why the problem isn’t worse
   ❖ Compared to the worst possible state people or this person could get in, how do they explain that it isn’t that severe? This normalizes and gets things in perspective.
   ❖ Compare this situation to the worst incident and find out if it is less severe. Then track why or how.

7. Get clients to teach you how to do what they do when things work
   ❖ Could they teach you or someone else how to do what works?
   ❖ Play other people in the situation and get them to coach you on how to act in a way that would produce better responses.
EXAMPLES OF COMPETENCY-EVOKING QUESTIONS

“What is different about the times when ____ (you are getting along, there are dry beds, he does go to school, and so on)?”

When a person reports something which appears to be new or different, even if they place little emphasis upon it, ask, “How is that different from the way you might have handled it ____ (one week, or one month, etc.) ago?”

When people talk about the problem pattern, ask about how the problem ended. “How did you get her to stop ____ (throwing the temper tantrum, nagging)?” “How did you get the fight to end?”

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“How did you get the fight to end?”

“Have you ever had this difficulty in the past?” If yes, “How did you resolve it then? What would you need to do to get that to happen again?”

Ask about hobbies, interests and things they do well. For example, “What subjects do you like best in school?” “What kinds of things do you do for fun?” “What do you do for a living?”

“You’re a marketing expert. Tell me how you sell things to people. Can you use similar ideas with your spouse?”

“Mother, you said you used to be shy and awkward around people, just like your kids are now. How did you overcome that?”

“Your marriage is in bankruptcy right now. How would you turn around your business if it were in danger of going under?”

“Tell me about the last time you started to get anxious or scared but somehow calmed yourself. What things did you do differently then?”

“You’ve had down times before and come out of them. So when you start coming out of the depression, what things do you start to do differently?”

“If you were on the golf course and you faced this kind of situation, how would you handle it?”

“I know you are unhappy with how much you weigh, but I am curious, how come you don’t weigh more?”

“You say you’ve already dealt with your sexual abuse and don’t need to talk about it any more. Can you tell me what you have learned from your dealing successfully with this issue that others might find helpful?”

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

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

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

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

“What effect does knowing that you’re resolved not to cut yourself anymore have upon your view of yourself?”
Method #1  Expectancy Talk

Use phrases that create expectancy, such as “yet,” “so far,” “up to now,” and “when.”

Example: So far you haven’t figured out any way to live and not be in misery.
Example: When you’ve gotten a handle on your anger, you won’t have so much trouble at work.

Method #2  Problems into Goals

Turn problem statements into goal statements.

Statement: I can’t stand this depression.
Your response: So you’d really like to find some way to feel better and be less depressed.

Method #3  The Crystal Ball

Ask people to envision a future in which the situation is better, a problem is resolved or a goal is reached. Then work backwards from that future to the present.

Example: I know you sometimes feel it’s impossible, but let’s just imagine it’s a year from now and you are feeling better, what kinds of things would you be doing if the depression weren’t dragging you down?

Method #4  The Miracle Method

Ask people to imagine that the barriers to reaching the goal are eliminated by a miracle while everyone is sleeping. Then ask them what things would be happening once the miracle had occurred. This does not involve hoping for a miracle, but freeing imagination and action from unnecessary limitations.

Example: Imagine that while you are asleep tonight, a miracle occurs and the depression has vanished. How would things change? What is the first thing you would notice or do when you woke up that would let you know the depression was gone?

Method #5  First Signs of Change

Ask people to tell you what the first signs of change will be that will indicate that they and the company are moving in the direction of the goals, the crystal ball vision or the miracle. [Hint: The first signs may already be happening.]

Example: What’s the first thing you would think or do when you are on the right track or have you already done something before we met that let’s you know you are heading in the right direction already?
Find out about other people who do not view the client or family as disabled, unable, sick or crazy.

Find out about hidden or non-obvious aspects of the person or the person’s life that do not fit or are incompatible with their disempowered (hopeless, helpless or stuck) views about themselves or the problem. Ask the person or his or her intimates how they explain the incompatibility.

Find out about their best moments in thinking about or experiencing themselves.

Connect them with others who may have experienced similar things or struggles and either found different ways to think about it or deal with it. This can be through books, tapes, letters, or support groups.

Normalize by letting them know that others have or do experience similar things.

Get the person and his or her family and friends to experiment with different ways of acting that are outside the usual expected identity patterns.

Encourage clients and significant others to avoid making premature conclusions and stories, but to stick with the experience and consider multiple stories and meanings.
What are you consistently paying attention to in the problem situation? What are you focused on that is not helpful?

Find anything else to attend to. Try:

1. Changing your sensory attention. Shift from seeing things to listening. Or from listening to touching.

2. In memory, try to recall other aspects of the situation you are remembering.

3. If you are stuck on some thought, think of one thing that would challenge that thought or get you to doubt it. Or every time you have the recurring thought or obsession, make yourself think of at least three things you could do in the present or the future that could change your situation for the better.

4. Shift from focusing on the past to focus on the present.

5. Shift from focusing on the present or the past to focus on the future.

6. Shift from focusing on your internal experience to focus on the external environment or other people.

7. Shift from focusing on others or the external environment to focusing on your inner world.

8. Ask yourself some different, more helpful questions than the ones you have been asking. What and How questions tend to be more productive than Why questions.

9. Focus on what has worked rather than what hasn’t.
SOLUTION TALK

This is “personal benchmarking.” You are going to start seeding the virus of solutions in the conversation when there is a problem. The idea is not to convince people that they have solutions and competence, but to ask questions and gather information in a way that convinces and highlights for them that they do.

**Method #1 Exceptions to the Problem Rule**
Ask people to detail times when they haven’t experienced the problem when they expected they would or solved the problem when they thought they wouldn’t. This includes exceptions to the rule of the problem, interruptions to the pattern of the problem, and asking about contexts in which the problem would not occur (e.g. home, in a restaurant, etc.) or in which they naturally solve problems well.

*Example:* “Tell me about the last time you started to get anxious or scared but somehow calmed yourself. What things did you do differently then?”

**Method #2 The End Game**
Find out what happens as the problem ends or starts to end. What is the first sign the person can tell the problem is going away or subsiding? What will the person be doing when their problem has ended or subsided different from what he or she is doing when the problem is happening or present?

*Example:* “You’ve had down times before and come out of them. So when you start coming out of the depression, what things do you start to do differently?”

**Method #3 Highlighting Choice**
Find evidence of choice in regard to the problem. Determine variations in the person’s reactions or handling of the problem when it arises. Are there times when he or she is less dominated by it or have a different/better reaction to it or way of handling it than at other times? Have the person teach you about moments of choice within the problem pattern.

*Example:* “I know things are really bad for you right now and most things that could change the situation seem impossible or beyond you. Is there anything that you can think of that you could do right now that could help?”

**Method #4 Find Contexts of Competence**
Search for other contexts of competence. Find out about areas in the person’s life that he or she feels good about, including hobbies, areas of specialized knowledge or well-developed skills, and what other people would say are the person’s best points. Find out about times when the person or someone he or she knows has faced a similar problem and resolved it in a way that he or she liked.

*Example:* “If you were on the golf course and you faced this kind of situation, how would you handle it?”

**Method #5 Worst Care Comparison**
This is a backwards way of identifying competence and solutions. Compared to the worst possible situation people or this person could get in, how do they explain that it isn’t that severe? Compare this situation to the worst incident and find out if it is less severe. Then track why or how.

*Example:* “I know you are unhappy with how much you weigh, but I am curious, how come you don’t weigh more?”

**Method #6 Tapping into Altruistic Expertise**
Ask people to help you help other people who might be experiencing the same issues what they have learned about what is helpful to solve or better the situation.

*Example:* “You say you’ve already dealt with your sexual abuse and don’t need to talk about it any more. Can you tell me what you have learned from your dealing successfully with this issue that others might find helpful?”
**SOLUTION-BUILDING STEPS**

**Step 1 Ask Solution or Exception Questions**
When there is a problem, being to build solutions by asking simple solution-evoking questions:

*What has been working?*

*Can you think of a time when you solved a situation like this?*

*Can you remember a time when you would have expected the problem to occur but it didn’t?*

**Backwards ways of finding solutions or exceptions**
Sometimes people will tell you or you will have the sense that there are no solutions moments to draw upon. There still may be a way to find solutions. At these times, use “backwards” ways of finding solutions by asking questions like:

*Why isn’t the problem worse? How have you or someone kept it from being worse?*

*Can you teach (or describe) how to create this problem if someone were going to learn to make it happen?*

*Can you teach (or describe) how to make this problem situation worse?*

*What happens as the problem start to subside or when things get a little better within the problem? What is the first sign you (or another person) can tell the problem is going away or subsiding?*

**Future methods of finding solutions**
What if there are truly no moments of solution or exception that you can identify from the past? No problem. Strangely, you can find solutions in the future, even though it hasn’t happened yet. Here are a few “future solution methods.”

**Scale the problem and the goal, then take small steps to move towards those goals**

*Where are you now on a scale of 1-10 or 1-100, the higher number being closer to where you want to be?*

*What number will you rate yourself (or your department or your company) when you reach your goal or solve the problem?*

*What would it take to increase your level by 1 point or more?*

**Future solution visioning and working backwards to the present**

*Imagine a future in which the problem either isn’t happening or has been resolved. What is happening in that future? Is there any action that you could take right now from that imagined future?*

**Step 2 Get a Specific Description of Actions, Difference or Change**
As soon as some moment or example of solution is discovered (and you often won’t discover it if you don’t go looking for it), the next step is to get details of how it came about. *How, not why.* When you first ask people to tell you how the exception came about, they will often tell you their theory or explanation for why the exception or moment of solution occurred. While this explanation may occasionally be helpful, most of the time it begs the question. Usually, you will need detailed descriptions of what someone did to make the situation work.
Getting a description of how instead of why can be helpful in two ways. The first is that a 1. *How* description contains information about actions, rather than theories, feelings, attitudes or circumstances that are hard to change by deliberate actions in the future. If the person says that things were better because it rained or that they just felt happier that day, they typically can’t have any effect on the situation in the future because they don’t directly control the weather or their mood.

2. People feel empowered to have some control over the problem—they aren’t just helpless victims of circumstances. In philosophy, they call this a sense of personal agency—that people feel they are agents who can choose and act rather than that they are being acted upon by others, the world or their circumstances.

**Step 3 Get a Specific Description of Interactional Difference or Change**

The next step often, in situations which involve more than one person is to get an interactional (or systems) description. It may take two to tango, but either person can change the steps of the problem dance to create a solution.

*When he or she changed, what did you do differently in response?*  
*When the situation was better, if someone followed you around with a video camera, would the video show you doing or saying anything different from what you would usually do or say in the more typical problem situation?*

**Step 4 Help People Bring the Solutions Evoked into the Present and the Future**

Many times people will spontaneously begin using the solutions that have been evoked. But if they don’t, there are some specific ways that you can help them put these solutions into practice in the present and the future.

Use language to move the solutions from the past to the present and the future

2. Change verb tenses from past to present to future when discussing or asking about the solution.  
   *Example: How did you keep from arguing? Then: How do you keep from arguing? Then: How will you keep from arguing?*

3. Use expectancy talk to create a sense of the inevitability of using solutions in the future  
   *Example: So you haven’t done what you use to do to get yourself out of this depression yet.*

Suggest trying some small experiment based on the solutions evoked  
*You said when you were feeling better about yourself you would be making more eye contact. Would you be willing to try looking people in the eye several times this week?*
OVERVIEWS
AND
SUMMARIES
OF
SOLUTION-BASED
THERAPY
1. Evoke rather than add from the outside
   a. Ask questions
   b. Investigate solutions, resources, competence, strengths, coping skills, pre-treatment change and abilities from the past and the present
   c. Ask about future preferences and problem-free times
   d. Be curious
   e. Don’t assume you know the truth or the right answers for or about the person
   f. Be careful not to add your own theories, explanations and labels

2. Draw on the past for resources and information
   a. When investigating the past, the therapist is not searching for causes or trauma but rather for resources
   b. Find out about any changes between sessions

3. Draw on the future for direction
   a. This approach is client-driven. Ask about their preferences for the future and problem-free or problem-reduced futures and be guided by those in therapy.

4. Be respectful and acknowledging of clients
   a. Note and comment on positive developments, productive change and positive coping.
   b. Respectfully listen to people’s pain, suffering and points of view without closing down possibilities for change.
   c. Be compassionate about their suffering but never assume that they are damaged, sick, ill, crazy or incompetent.
Seven Steps in Solution-Based Therapy
Bill O’Hanlon, M.S., Possibilities, 223 N. Guadalupe #278, Santa Fe, NM 87501 USA
www.bilohanlon.com; email: PossiBill@aol.com

5. Create an atmosphere of change and possibility (through language, assessment methods and nonverbals)
   a. Use possibility language
   b. Assume change can happen
   c. Do not assume irrevocable damage or pathology
   d. Ask about future preferences for therapy outcomes and for life

6. Acknowledge pain, suffering, problems, explanations, feelings and points of view while keeping possibilities for change open
   a. Validate current reality without assuming that things will stay the same
   b. Listen without trying to make things more positive than they seem to the person who is speaking about the situation

7. Orient to preferred future and goals
   a. Find out what people want out of therapy or what the minimal change they would hope for would be
   b. Connect people to hope and futures with possibilities

8. Track problem patterns (viewing/doing/context)
   a. Have people teach you how to “do” the problem
   b. Find typical viewpoints of people involved in the problem situation
   c. Find where the attention is focused in the problem situation
   d. Find out what happens around the problem situation socially
   e. Find any time or spatial patterns or regularities in the problem situation

9. Elicit solution patterns (viewing/doing/context)
   a. Explore exceptions to the problem
   b. Explore positive coping methods and times
   c. Find any context in which the problem would not occur
   d. Find out where attention is focused in non-problem moments or times
   e. Identify any alternate stories or ideas that are different from typical or problematic stories or ideas

10. Introduce or notice small changes
    a. Identify anything anyone involved in the problem situation is willing or able to do to make a small change in viewing, doing or context
    b. Usually this will involve some rigidly repetitious aspect of the problem situation; It might involve deliberately taking some action that is part of the solution patterns evoked or identified

11. Connect with or evoke motivation
    a. What are people involved in the problem situation motivated for and what are they motivated away from or to avoid?
    b. Experientially connect people to their motivations in order to bring about change in the problem situation
Acknowledging, Validating, and Valuing
* It is important to attend carefully to clients, acknowledging their points of views and feelings. It is also important to communicate a basic liking for and valuing of the person. One can also give a sense that the points of view and feelings of the person are valid or within the realm of normal human experience.

Clarifying Concerns, Complaints and Goals or Directions
* Collaboratively explore clients’ concerns and complaints, that is, what they believe is troubling enough to have sought your help. The idea to seek help may be someone else’s and it is just as important to explore this. Then find out what the clients’ (and/or the people who think the client needs help) view of what would constitute a successful outcome. Get such goals, outcomes and destinations in action terms (so that one could see and hear what would be happening at that time). If the client doesn’t want goals that are so specific, one can always inquire about directions that would be preferred rather than specific outcomes.

Changing the Viewing, the Doing and the Context
* Help people challenge patterns of their meaning-making (stories), what they are attending to, patterns of action and interaction, and any aspects of the context around the problem (cultural, gender, family background, neurological/physiological, spiritual aspects of clients’ lives).

Evaluating Progress, Results and Outcomes
* Check in with people throughout the process to find out whether what you are working on with them is relevant and helpful. Use scaling and percentage questions, as well as feeling questions to assess how things are going according to clients.

Planning Next Steps
* Plan assignments for out of session experiments. Ask about when the next meeting should be according to them. Ask people whether they want to come back, whether they have made enough progress in the direction they wanted to stop the process of counseling or therapy or to take a break. Plan follow-up contacts and relapse prevention or recovery.

Terminating Treatment
* Stop treatment by mutual agreement, leaving the possibility open for return for any future problems or recurrence of previous problems.
SOLUTION-BASED THERAPY BIBLIOGRAPHY

Bill O’Hanlon, M.S., Possibilities, 223 N. Guadalupe #278, Santa Fe, NM 87501
505.983.2843; PossiBill@aol.com; http://www.billohanlon.com


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