Solution-Focused Therapy with Adolescents in Residential Treatment

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Abstract

This article provides a solution-focused approach for working with adolescents in residential treatment. The content areas include: (1) a discussion of why solution-focused therapy is a salient treatment modality, (2) a review of the philosophical underpinnings of solution-focused therapy, (3) casting a vision for the therapist's disposition toward the client, (4) a solution-focused understanding of mental illness and medications, (5) a discussion of solution-focused therapy techniques, and (6) a brief discussion regarding how to talk about setbacks.

Seven days of residential treatment has been authorized by your new client's insurance company. The client is presenting severe symptoms, and has a family system of strained relationships that are all too familiar. Your new adolescent client is refusing to talk with his or her parents, aside from demands to be removed from residential treatment. You're scrambling to formulate a diagnosis, develop a treatment plan, and get a handle on the client's treatment history. To top things off your supervisor wants to know the discharge plan!

Sound familiar? If it does, then no doubt you have experienced the pressure and time constraints common in residential treatment. Given these conditions, the question is not why solution-focused therapy is needed in residential treatment centers; rather, the question is how could any therapist effectively treat an adolescent without adherence to a brief therapy approach? The culture of managed care almost universally demands residential treatment be "short-term" (Leichtman, Leichtman, Barber, & Neese, 2000). The increasingly strict criterion used by insurance companies to substantiate the need for a "higher level of care" has led to substantial decreases for the average length of treatment within the residential context. The speed at which clients pass through residential programs places additional responsibility

upon residential therapists to maximize the opportunities they have when interacting with clients and their families. In order to be good stewards of the clients' resources and time, residential therapists need to consider adopting a solution-focused or brief therapy orientation.

"Failures" of Treatment

The myriad of messages adolescent clients receive from parents and from previous treatment providers are often permeated with defeat, deficit, and blame. Most adolescents in residential treatment possess multiple experiences with inpatient hospitalizations, partial hospital programs (PHP), intensive outpatient services (IOP), and traditional outpatient services (Leichtman et al., 2000). These past treatment experiences are frequently labeled as "failures." The memories and messages associated with these "failures" are carried with the adolescent into residential treatment. It is easy to understand why an adolescent client's self-esteem may be shattered. Solution-focused therapists must orient themselves away from this negativity and strive to disrupt the "stories of impossibility" that are self-perpetuated by clients and their families (O'Hanlon & Bertolino, 1998).

Focusing on Solution Possibilities

A fundamental concept of solution-focused therapy is shifting the client's frame of reference from problems to possibilities (De Jong & Berg, 1998; Miller, 1997). This is best accomplished by engaging clients in solution-focused language instead of the familiar problem-focused language (Miller & de Shazer, 1998; de Shazer & Berg, 1992). Clients and families utilizing problem-focused language often cling to the idea (consciously or unconsciously) that in order for change to occur, the problem must be completely resolved. This faulty assumption can be particularly difficult to overcome because with each treatment "failure" the adolescent's identity may become increasingly fused with the problem, sometimes to the point where the problem and the client are virtually synonymous (Schott & Conyers, 2003). The problem is difficult to resolve if this equation (problem = adolescent) persists. This is a reason why many families and clients feel so stuck by the time residential services are activated.

Therapists who engage clients and their families in solution-focused language seek to reshape and reconstruct their rigid and

dichotomist thinking. Solution-focused therapy purposefully utilizes "solution-talk" and avoids "problem-talk" (de Shazer, 1994). Through "solution-talk," therapists assist clients and their families in seeing that a positive treatment outcome does not necessitate the complete resolution of the problem. Instead, success is measured in terms of improvement in the adolescent's and the family's functioning. *The goal becomes life improvement, not problem resolution.* De Shazer (1994) points out that "Of course not all talk about problems is problematic. Sometimes, in fact, it is useful, for instance, if the client has never talked to anyone about the problem, then talking about the problem is doing something different" (p. 80). There are positive ways to talk about problems and there are problematic ways of talking about problems. The path chosen is jointly determined by the quality and types of interactions occurring between the therapist and the client (i.e. use of "solution-talk" vs. use of "problem-talk").

While many therapists agree with this notion (i.e. a need to focus upon solutions), it can be very difficult in practice for therapists to maintain a positive outlook when working with clients who have severe mental disorders. If the therapist slips into a problem-focused mode of thinking, this may negatively impact clients, their families, and the culture of the residential treatment center. Solution-focused therapists typically strive from the onset of treatment to steer the orientation of clients and their families toward realistic solution possibilities. The language used by the solution-focused therapist is the primary vehicle for constructing a social reality that possesses these new possibilities (G. Miller, & de Shazer, 2000). Accordingly, solution-focused therapists should advocate and intercede for their clients whenever this new reality is jeopardized or challenged. Attacks to this new reality sometimes emanate from the residential treatment center itself. Staff may slip into problem-focused modes of thinking about and relating to the adolescent in care, and clients and families may revert to old habits of blaming.

Constant Change
Another fundamental principle of solution-focused therapy is the belief that change is constant and that only small changes are needed in order to generate positive movement in the lives of clients (de Shazer, 1985, 1988). The principle of constant change is one that is often hard

for clients, families, and even therapists to grasp. While the genetic traits of clients are fixed, clients and their families possess the ability to alter how they interact with and perceive the social, environmental, emotional, and spiritual aspects of their lives. If change is constant, then it is wise for solution-focused therapists to ask clients and their families about any pretreatment changes occurring prior to admission. In Lawson's (1994) study on pretreatment change with a sample of 82 clients, 51 clients (62.2%) were able to identify positive pretreatment changes. An earlier study conducted by Weiner-Davis (1987) found that out of 30 cases consisting of adolescent clients and their parents, 20 cases (66%) reported the existence of positive pretreatment changes. Change is constant, yet if this reality is not pointed out to clients and families they often remain stuck in a distorted reality where problems are static.

Another fundamental principle of solution-oriented therapy is that only small changes are needed in order to usher in greater changes for clients. While society and the therapy community often talk about "random acts of kindness," "the butterfly effect," and Dr. Leo Marvin's philosophy of "Baby Steps" from the movie *What About Bob?*, more "power" resides in these clichés than people may believe. Within the context of residential programs, solution-focused therapists ask their clients to observe what happens in their lives when they do something different that is seemingly small or appears insignificant (e.g. daily hygiene, risk disclosing to staff, remaining in the social milieu instead of isolating, talking to their parents without making accusations, simply identifying positive aspects about the self). These are examples of small steps clients can take that open up new experiences and new pathways to solution possibilities. One key concept to remember during this entire process is that change is constant and clients are capable of discovering new ways of relating and behaving.

Doing What Works
The guidelines of "do more of what works" and "if it works, don't fix it" are cornerstones of solution-focused therapy (de Shazer, 1985). Astute residential therapists are able to quickly assess the client's past attempts to resolve the problem by classifying these attempts into "useful" and "not useful" means of handling the problem. Many times it becomes clear that attempted solutions are often the source of

problems or responsible for their reoccurrence (Watzlawick, Weakland, & Fisch, 1974; Fisch, Weakland, & Segal, 1982). In these situations, solution-focused therapists encourage clients to explore new ways of coping with the problem, as well as seeking to eliminate old coping habits that have proven to be ineffective. During the process of identifying what works for clients, solution-focused therapists are also directing attention toward the unique strengths and characteristics of clients, specifically asking them to share about their talents, interests, and personal strengths. These areas of strength are then used by the therapist to amplify the client's movement toward solutions. This process of highlighting the positive elements and events of the client's life is particularly needed for adolescents in residential care, who as mentioned earlier, frequently view themselves through negative lenses.

Therapist's Disposition toward the Client

Client as Expert

The attitude and disposition of the therapist toward the client is paramount. Will residential therapists assume the attitude of judge and jury, or will they choose a different stance? There is little doubt about the preparedness of the adolescent to receive criticisms and judgments from the therapist. But is the adolescent client prepared for a solution-focused therapist, someone who will place him or her in the role of expert? Many clients who are admitted to residential treatment centers feel as though they have been wronged and/or tricked into treatment, similar to the feelings common among mandated clients. It is also common for adolescent clients to claim they have no voice, or that no one has listened to them in the past. It is recommended that solution-focused therapists take the stance of "not knowing" and invite their clients to educate them about what they know works best for them (De Jong & Berg, 2001). By taking this stance with clients, solution-focused therapists can improve their ability to cooperatively build and construct solutions with clients. When allowed to be the expert on their lives, adolescent clients usually take more responsibility for their own treatment and work with their parents and therapist in a more productive and mutually agreeable manner.

Building Healthy Expectations

Once adolescents see the therapist is genuinely interested in cooperating with them and the therapist values their stories, then the seeds of hope are planted. Adolescents may begin to wonder to themselves, "Will this treatment experience actually be different?" Through use of a solution-focused stance, a healthy sense of expectancy for the realization of solution possibilities begins to become tangible to clients. In order for this to occur the therapist must be genuine and present, fully listening to and acknowledging the stories, emotions, and competencies of clients (S. D. Miller, Duncan, & Hubble, 1997). If this is neglected, then adolescents (who are adept at "sniffing-out" falsehood) will throw-up their defenses and disengage from the therapeutic process.

A Solution-Focused Understanding of Mental Illness & Medications

Mental Illness as "The Problem"

The amount of exposure adolescent clients have experienced with diagnostic labels, combined with the different stories about these labels from various professional and non-professional sources, often makes mental illness "the problem." Mental illness becomes a significant problem when clients disavow personal responsibility for their poor choices and acting-out behaviors. Frustrated with their child's behavior, exhausted parents sometimes blindly accept diagnostic labels that describe their child's misbehavior and emotional instability, framing it as stemming from mental illness. This can lead them away from considering the multiple contributing factors responsible for the adolescent's current psychological state. This is a potentially combustible issue, one solution-focused therapists will likely have to navigate with each child and family. DSM-IV-TR labels are not the problem; the problem is the tendency of clients, parents, and even treatment providers to view diagnostic labels as the final formulation about an adolescent's current state and about his or her ability to change. The linear thinking characteristic of western societies, particularly in regard to cause and effect, makes it difficult for individuals to not believe in narrow definitions of mental illness. While this article does not allow for a full discussion of this intriguing subject, solution-focused therapists need to be prepared to have such

discussions with their clients and families. While most parents and adolescent clients admit to the presence of mental illness, there may be some rare situations where such a formulation is not accepted. In either case, solution-focused therapists strive to cast a vision for life enhancement, challenging clients to have the courage to be healthy and to move in a socially useful manner whatever their diagnosis may be (Ansbacher & Ansbacher, 1956; Mosak & Maniacci, 1999; LaFountain, 1996).

It is common for clients and parents to want to know the cause or reasons for the adolescent's problems. In these cases, the solution-focused therapist may answer that such investigations and interpretations could be endless, and the focus of therapy should be concerned about the present and the future (de Shazer, 1994; Watzlawick, Bavelas, & Jackson, 1967). While it might be intriguing to identify a cause for a problem, there is no guarantee that the cause being investigated is still operating upon the problem. In other words, the problem may have "functional autonomy," meaning that it is self-perpetuating in-and-of-itself and the original "trigger" or "cause" is no longer a factor. The solution-focused therapist should empathize with clients who desire to know the "truth" about causes, while redirecting their energies to the here-and-now.

Medications as "Helpers"

It can be very difficult to help adolescent clients understand the benefit they may receive from taking medications for an extended period of time, and that this reality can coexist with a positive outlook on life. Just as people with diabetes learn to acknowledge the presence of specific limitations and the need for specific safeguards in order to remain healthy, it may also be important for clients to acknowledge the presence of emotional and behavioral limitations, some temporary and some enduring. The solution-focused therapist strives to help clients be as practical and pragmatic as possible. Adhering to malignant optimism usually only serves to disadvantage clients and their families, whereas honest dialogue and hope based upon reality can be more constructive and edifying. Solution-focused therapists must embrace the paradox of acknowledging limitations, while also maintaining that there are several unknown solution possibilities available to the client. While it may not be possible to rid some clients from diagnostic labels

of the DSM-IV-TR or their need for medications, it is possible to amplify client strengths and abilities.

Clients who are admitted to residential treatment centers are typically on medications. While there are significant reasons and indications for the use of medications, clients need not be mindless recipients. Solution-focused therapists need to be willing to have conversations about medications and should encourage their clients to talk with their psychiatrist or physician about each medication and its potential benefits and possible side effects. It is very useful to frame medications as "helpers." This is practically a universal euphemism among mental health professionals that is very positive and strength-based in orientation. Framing medications as "helpers" keeps clients responsible for their own behaviors and minimizes their ability to complain about the influence or lack of influence of a medication.

Solution-Focused Techniques in Residential Treatment

The Miracle Question with a Twist

The miracle question is a useful technique for assisting adolescent clients to identify and clarify goals for life improvement. While the miracle question can be helpful in its "traditional" form, therapists may need to modify it to the specific needs of their clients. The traditional" miracle question is formulated as:

> Suppose that tonight after you go to sleep a miracle happens and *the problems that brought you to therapy are solved immediately*. But since you were sleeping at the time you cannot know that the miracle has happened. Once you wake up tomorrow morning, how will you discover that a miracle has happened? Without your telling them, how will other people know that a miracle has happened? (emphasis added, de Shazer, 1994, p. 95).

Instead of offering the "traditional" version of the miracle question (implying the complete resolution of client problems and complaints), it may be more respectful when working with adolescent clients with severe DSM-IV-TR diagnoses (e.g., schizophrenia, bipolar disorder, major depression) to ask the miracle question differently. The solution-

focused therapist who is working in a residential setting is advised to replace the italicized portion of the "traditional" formulation with one of the following phrases: "The miracle is that life is improving" or "The miracle is that your life is on-track to getting better." The difference with this version of the miracle question is that it subtly communicates respect for the realities of the client's emotional and behavioral limitations while still maintaining a solution-focused perspective regarding the client's ability to improve. The power of the miracle question is that it serves as a bridge to connect clients and therapists as well as orienting each to the future (de Shazer, 1994, p. 95). While the "traditional" version of the miracle question is very useful and helpful for many clients, it may not be the best choice for clients who have experienced and are experiencing severe psychological and behavioral disturbances.

Positive Coping

Adolescent clients in residential treatment centers are often well versed in the therapeutic jargon of mental health. A common part of this verbiage is the concept of coping. It is often humorous to witness the reactions of adolescents in residential treatment when a conversation moves into a discussion about coping, especially when in a group setting. Adolescent clients often moan and groan about coping skills and anger management techniques because in most cases they have been able to identify coping strategies, yet have failed to consistently utilize them. The dark side of coping is the valley of shame clients can fall into after they fail to adequately cope with stressors in their life. Adolescents are sometimes reluctant to talk about coping because of this strong association with failure.

The solution-focused therapist's positive stance on coping is a way to counteract this pattern. Instead of asking how a client failed to cope in a particular situation, solution-focused therapists emphasize the possibility of improved coping in the future. In situations where the adolescent partially coped or coped well for a period of time before making a poor choice, the solution-focused therapist highlights the fact that the adolescent was able to successfully cope as long as he or she did. Questions such as "How did you do that?" and "What were you telling yourself when you noticed you were coping well?" are appropriate for accomplishing this goal (De Jong & Berg, 1998).

Clients are often surprised when the therapist celebrates partial successes instead of examining how they "messed up." Of course, it is unavoidable that family members and clients will identify and want to talk about what went wrong, and possibly who did what to make the situation worse. Solution-focused therapists accept this reality, yet encourage the family to identify what went well and how things can improve.

Case Example

A female adolescent client was praised by her therapist in a recent session. Why? Prone to physically attacking her parents and throwing household items when upset and angry, in her most recent outburst she only kicked over a small trash can. While the hostility and anger still existed between the girl and her parents, something had changed. The girl's mother recalled at one point in the episode her daughter had a chair in her hands, and the mother was fearful that she was going to throw it down the stairs. The daughter quickly chimed in by stating that she had considered throwing the chair, but she had changed her mind because she didn't want to accidentally hurt someone in the family. This revelation helped to alter the girl's distorted perception of herself from the negative problem-talk, "I am someone who hurts my parents" to the positive solution-talk, "I am someone who cares about my parents." The disclosure also helped the parents to see their daughter in a positive light (i.e. "she cares about our safety"). This solution-focused perspective on coping helped to open up new possibilities for this client and her family. It is not uncommon that even in the midst of considerable negativity, adolescents and their families are able to identify positives and solution possibilities when they are guided by a solution minded therapist. Families are frequently able to discover these realties even on their own.

Scales

A common challenge faced by many adolescent clients in residential treatment is a limited vocabulary, or a reduced ability to translate their subjective experiences into a language that is understandable by others. A shrug of the shoulders, a blank stare, and the common statements "I don't know," and "I'm fine," are indicators this phenomenon may be occurring. Solution-focused therapists accept these responses and may state "It's difficult to know how to describe your thoughts/feelings,"

or "It makes sense that it might be challenging to share about your experiences." Therapists need to be aware that some of their clients might have developmental delays in cognition, attention, auditory reception, and memory, and clients may be several academic grade levels behind in school. The presence of learning disabilities may restrict the client's ability to participate in treatment when compared to a "normal" adolescent. In light of these challenges, the utilization of concrete tactics to assist clients with sharing about their experiences is very helpful. One tactic that consistently helps is the use of scaling questions.

Scaling questions are particularly helpful because they provide a vehicle for talking about subjective experiences. Consider which mode of inquiry is easier for the adolescent client who is depressed: (a) responding to an open ended question that demands a vocabulary to describe the feelings, thoughts, and behaviors of his or her depression, or (b) responding to a scale from 0 to 10 upon which he or she may identify thoughts, feelings, and behaviors? For example, an adolescent may be asked to identify where he or she is at on a scale; 0 equals where the client was at during the time of admission (e.g. severely depressed) and 10 equals where the client will be at the time of discharge (e.g. little or no depression). If a client states that she is at a 5, then the therapist inquires about how she knows this (i.e. what are the signs or behavioral clues at a 5). Then the solution-focused therapist asks the adolescent to describe how her thoughts, feelings, and behaviors will be different when she is at a 6 or 7. The use of scales helps clients to describe and understand where they currently see themselves in terms of what is being assessed (in this case depression). Scaling questions can also build healthy expectations for future improvement.

"On-Track" Assessments
Once a good working relationship has been established between client and therapist and when the goals for therapy begin to solidify, it is important for the solution-focused therapist to "check-in" with clients about their progress. Life improvement and the solution movements of the client are assessed through "on-track" assessments (Walter & Peller, 1992). The "on-track" assessment asks clients to identify if they are moving toward their treatment goals. Adolescent clients are asked to identify clues or signs telling them they are "on-

track" toward reaching their goals. Once these are identified by the client, the solution-focused therapist asks a variety of questions assessing how difficult or easy it was to stay "on-track" in a particular situation. The therapist may inquire about what adolescent clients actively do to keep themselves "on-track," and the therapist may also ask about how mindful or aware clients are when they are purposefully moving forward. Clients who are close to discharge and who have demonstrated consistent solution movement are asked to keep noticing what helps them to stay "on-track" (Campbell, Elder, Gallagher, Simon, & Taylor, 1999). If adolescents assess that they are "off-track" or even "derailed," questions about what it will take to get them back "on-track" are asked.

Finding the Funny Bone

There is a significant amount of literature about the health benefits of humor, and therapists are wise to harness its power. In Martin's (2001) review of the existing psychological studies on humor from 1960 to 2001, he discerned three explanations or reasons for the efficacy of humor: (1) positive physiological changes, (2) positive emotional states, and (3) improved coping with stress. While it is difficult to identify exactly how humor provides health benefits to individuals, it has been commonly agreed that life is more enjoyable with humor and laughter. As mentioned earlier in this article, many adolescent clients who enter residential treatment have a negative self-concept and outlook on life. Solution-focused therapists are encouraged to consider the power of humor and how it may benefit clients and families. The "silly" and "sarcastic" forms of humor are not indicated; instead therapists should utilize and foster a "relaxing" or "light-hearted" humor that stems from their positive regard for clients. The first step toward establishing the good humor connection with clients comes from the attitude of the therapist. Light-heartedness and the ability to smile and rejoice about client successes can be intoxicating to adolescents who feel stuck in a pessimistic frame of reference. Solution-focused therapists who are able to discern and then skillfully tickle a client's funny bone will no doubt aid the client with changing his or her outlook on self, others, and the world.

Solution-Focused Perspective on Setbacks

Bumps in the Road

How do solution-focused therapists talk about setbacks with adolescents in residential treatment? The answer is usually through metaphor. Much of therapy is metaphorical, sometimes purposefully and sometimes unintentionally. When it comes to talking about setbacks, describing these events as "bumps in the road" instead of relapses removes much of the stigma and negative connotations tightly wound around this concept. When an adolescent client is informed that bumps in the road are common and that they are expected to occur due to the complexities of life, this helps remove much of the destructive power of setbacks when they happen. The imagery of a road can be very useful because the adolescent client is able to identify that life is a journey. The road of life can be long and unpredictable, and it can be hilly, curvy, smooth, bumpy, narrow, and wide. Adolescent clients can be asked to describe how they see the roads in their lives. Is the road with their peer group smooth or bumpy? What about the road with one's parents? How is the road of education? The permeations and versatility of this technique is limited only to the imagination of the therapist and the client. A road may be bumpy but if there are several rest stops along that road then the journey is more bearable. If bumps in the road are predicted then life can become a bit more predictable. If life is more predictable then the ability of clients to positively respond to setbacks can be enhanced. If adolescent clients learn how to responds positively to the bumps in their roads then they will likely be able to more fully enjoy life when the ride is smooth.

Implications for Therapists

Residential therapists should consider adopting a solution-focused approach because it is an effective treatment model given the constraints of managed care. Solution-focused therapy effectively addresses the negativity often engrained in the lives of clients. This approach provides a refreshing alternative for talking about the problems and challenges that adolescents are confronted with and provides realistic hope for change. As clients begin to view themselves in a more positive light and as they experience small changes, the solution movement of the client becomes easier to generate.

While the allure of being solution-focused is appealing, it is often very difficult for residential therapists to adhere to this approach given the attitudes of clients, parents, and the treatment culture of the mental health field (which often dwells upon problems and primarily uses "problem-talk"). Being solution-focused in the office with clients is only one manifestation or outlet for this perspective. Therapists should be solution-minded when interacting with direct care workers who provide daily support and structure for clients. Solution-focused therapists are encouraged to be intentional about influencing the treatment culture of residential programs and should challenge coworkers to consider the possibilities that "solution-talk" reveal. Through adherence to a solution-focused perspective, residential therapists can positively impact clients, families, and the environment of care.

Solution-focused checklist

As mentioned earlier, it can be challenging for therapists who work in residential treatment centers to maintain a solution-focused perspective. Having a simple checklist as a reminder of what to look for in therapy can prove helpful. Most solution-focused therapists want to assess their client's beliefs and attitudes. Gaining a general idea about where the client is in each of the categories listed below will likely assist in the formulation of treatment goals. The following checklist is not intended to replace other psychological instruments used to formulate diagnostic labels or determine personality functioning. Instead, this checklist serves as a guide for solution-focused therapists who want to gain a baseline of a client's level of solution focus and problem focus orientations. This checklist can also be used by therapists to assist in conceptualizing parental belief systems. It also may prove useful to implement this checklist for the purpose of self-evaluation (even therapists need to take stock of how they are doing).

- Client's Stories about Self (Tales of Impossibility vs. Tales of Possibility)
- Client's Relationships with Others (Draining vs. Fulfilling)
- Client's Words (Problem-Talk vs. Solution-Talk)
- Client's View of Future-Self (Negative Future-Self vs. Positive Future-Self)
- Client's View of Responsibility (Other-Determined vs. Self-

Determined)
- Client's Ability to Forgive Self (Self-Deprecating vs. Self-Forgiving)
- Client's Movement (Problem-Generating vs. Solution-Generating)
- Client's Humor (Degrading Humor vs. Up-Building Humor)
- Client's View of the World (Hopeless-Hostile vs. Hopeful-Cooperative)
- Client's Exception Finding Ability (Limited vs. Numerous)

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