Developmental Adaptations of Solution-Focused Family Therapy

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Solution-focused interventions emphasize exceptions to problems and the future without a problem. However, certain cognitive abilities are required to enable clients to delve into the past and detail nonproblem times, and then think about how to apply these blueprints to the future. Since children and some teenagers still think in concrete ways, solution-focused techniques need to be adapted to meet the developmental requirements of youth. In this article, the adaptation of techniques will be illustrated in the context of solution-focused family therapy for the treatment of behavior problems in children. [Brief Treatment and Crisis Intervention 2:301–313 (2002)]

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While solution-focused therapy shares with other family therapy models a focus on the contextual nature of behavior, its unique focus is on exceptions, times when the problem is not a problem (de Shazer et al., 1986). The practitioner helps the family identify resources used during exceptions and then how to amplify strengths and apply them to problem situations. Solution-focused therapy also focuses on the future without the problem. Interventions, such as the miracle question and solution-focused scales, ask clients to detail life without the problem, with an emphasis on how the problem is contextually related.

Certain cognitive abilities are required to enable clients to delve into the past and detail nonproblem times, and then think about how to apply these blueprints to the future (Selekman, 1997). Children and even some teenagers still think in concrete ways. It is only in the next stage of cognitive development, formal operations, in which individuals can represent cognitively what exists in reality. Abstractions, such as exception-finding, applying exceptions to problem behavior, evaluating the consequences of behavior, and tracing action to bring about preferred outcome, cannot be easily understood or represented mentally by those who have not reached this stage. In order to overcome the cognitive
limitations of children and teenagers, certain techniques must be modified (Selekman, 1997).

This article will discuss how to adapt solution-focused techniques to youth with behavior problems at three different developmental levels: very young children (ages 5 to 7), school-age children (ages 8 to 11), and adolescents (ages 12 to 17). Because this article has such a specific focus on how to make interventions more relevant for children, the interested reader is referred to de Jong and Berg (1998) in order to understand basic interventions. See Durrant (1995), Murphy (1997), and Selekman (1993, 1997) for other ideas on how to work with teenagers and children.

This article will be organized according to the following techniques: engagement, identifying resources through exceptions, and scaling questions. Techniques will be described along with their application to children of different developmental stages for child behavior problems. Child behavior problems will be the focus since one-half to one-third of all referrals to outpatient clinics involve such problems (Kazdin, 1995).

Engagement

Joining involves building a basis for collaborative work (Berg, 1994; de Jong & Berg, 1998). Engagement strategies take into account the relationship of the client to the helping process and use various strategies for different client relationships. Joining begins, however, with the simple act of making small talk with the client (Berg, 1994; O’Hanlon & Weiner-Davis, 1989). Small talk can revolve around the situation that the practitioner and the client share, such as the office location (“Did you find this place okay?” “Did you find a place to park?”) or the weather (“It’s really coming down out there.”). Young children can be asked about their ages, their grade, what they’re doing in school, what they like to do, their siblings. School-age children and teenagers can be asked about what they’re good at, their hobbies and interests, and musical tastes (Selekman, 1993, 1997). One teen, a 16-year-old Hispanic girl named Connie, on probation for marijuana use, identified that she liked to exercise.

Practitioner: Good deal! What do you do for exercise?
Connie: Well, my mom and me usually work out at _____. but I haven’t lately.
Practitioner: You and your mom together?
Connie: Yeah.
Practitioner: Well, that’s great that you do that together. I don’t know too many daughters who work out with their mothers.
Mother: She goes jogging a lot by herself, too.
Practitioner: Do you really? That’s great.
Mother: She’ll get mad, and sometimes she goes because she is so stressed out.
Practitioner: That really is an awesome strength. How does it make you feel when you’re running?
Connie: It’s like I’m releasing all my stress, and I’m like in a good mood all the time.
Practitioner: That’s great. That’s a real healthy coping mechanism.
Connie: Yeah.
Practitioner: And how do you feel after you’ve done it? When you get home from running, how do you feel right afterwards?
Connie: Energized. You know, I am not real mad or anything, just . . . and when I even exercise, I don’t feel like smoking either.
Practitioner: Really? Talk about killing two birds with one stone.

This practitioner joined with Connie by finding out what she liked to do. When the client identified a positive activity, the practitioner reinforced this through complimenting and trying to build on the strength as a way to cope with her anger and urges to smoke marijuana.
Client Relationships

In solution-focused therapy, there are three main types of client relationships: the customer (the voluntary client wanting to make changes), the complainant (more interested in change for another), and the visitor (the involuntary client who has been mandated to attend) (de Jong & Berg, 1998). When parents bring their child to treatment for behavior problems, two types of client relationships are typically present. Parents usually present with the complainant-type relationship. They see their children as the problem and want change to come from them. Children with behavior problems are typically engaged in the visitor relationship. They are generally less concerned about their behaviors than are others (their parents, the school system, the courts). Their main goal is to terminate treatment. Strategies to engage the complainant and the visitor relationship will be detailed below.

Joining With the Complainant Relationship

Joining with the complainant involves asking coping questions, normalizing, reframing, asking questions about what is wanted rather than what is difficult and eliciting details from clients about the context, including how the individual plays a role in the solution (Berg, 1994; O'Hanlon & Weiner-Davis, 1989).

Coping Questions

Coping questions are one way to join with parents who complain about their children’s behavior problems. If complainants’ struggles are not validated, they will not readily engage in “solution” talk. Coping questions are used, however, not only for validation of the client, but also to elicit from parents the coping skills and resources they have used to manage their difficult home situation. For example, Mrs. Jackson, a grandmother, had recently received custody of her two grandchildren after her son was imprisoned and her daughter-in-law abandoned the children due to substance abuse. Mrs. Jackson complained a lot about how Louise, the six-year-old, lied and didn’t clean up after herself, and that Eric, the five-year-old, didn’t talk and make enough eye contact. She complained that both children didn’t listen to her.

Mrs. Jackson was asked (when the children were not present), “You sure have a lot on your plate right now, having two young kids to take care of. You work and you’ve already raised children of your own. How are you able to manage?”

Mrs. Jackson: Well, it’s not easy.
Practitioner: I know, how are you doing all this?
Mrs. Jackson: What else am I supposed to do?
Practitioner: You had a choice here. You didn’t have to do all this. But you made the choice to keep the kids with you.
Mrs. Jackson: I’m probably too old for this.
Practitioner: It must be hard. How are you managing?
Mrs. Jackson: I’m a strong person. I’ve always been strong.

When people complain about how the problem impacts them, coping questions not only give them validation for their difficulties, they also push the client to identify the resources they use to keep going in the face of adversity (Berg, 1994; de Jong & Berg, 1998). Mrs. Jackson might have resisted attempts to focus on the positive aspects of her grandchildren’s behavior until this conversation between herself and the practitioner took place.

Normalizing

Normalizing is a solution-focused technique to depathologize people’s concerns and present
them instead as normal life difficulties (Bertolino & O’Hanlon, 2002; O’Hanlon & Weiner-Davis, 1989). The rationale for normalizing has to do with the origins of solution-focused therapy, which stem in part from MRI brief therapy. In MRI brief therapy, family systems are conceptualized as operating under feedback loops (de Shazer et al., 1986). When a negative behavior occurs (child disobeys), the parent may apply behavior to get the child’s behavior back under control, but this may sometimes have the effect of increasing the child’s misbehavior rather than decreasing it, and the feedback loops keep escalating.

With children, sometimes parents have expectations for children beyond their developmental stage. The feedback loop begins with the child not meeting the parent’s expectations and the parent becoming frustrated. When a parent is frustrated and places pressure on a child, some children will be even less likely to perform new behavior under these circumstances. Normalizing might involve educating parents on what children at certain levels can do.

For example, Ms. Gomez, the mother of six-year-old Hector, complained that her child wouldn’t do his homework. She would make him stay at the kitchen table until he was done. Sometimes this would continue for up to an hour and a half by which time the homework would not only still be incomplete, the child would have grown frustrated to the point of tantrumming. The mother at this point was also extremely frustrated and the relationship between them had deteriorated.

The child’s inability to sit still and attend to task for this period of time was normalized. The practitioner explained that children at this stage are unable to concentrate after about 20 min of work. This information helped Ms. Gomez to scale back her expectations, so that unnecessary problems weren’t created.

Like Ms. Gomez, many parents of school-age children expect more from their child in terms of concentrating and remaining still beyond what a child can sustain. For example, in session parents often scold their children for fidgeting. The practitioner can normalize this behavior for parents; some physical activity from children is acceptable as it is difficult for children to concentrate for a 50-min session. Indeed, as long as they participate in session, children can be allowed to move around the room or be active through drawing. The activity sometimes allows children to focus more on session material as their anxiety about being under scrutiny can then be lessened.

For parents of teenagers, normalizing can be around aspects of the adolescent’s developmental stage. Musical taste and dress style are two common examples. Ms. Peterson, the mother of 13-year-old James, started the first session worrying that her son was involved in satanic worship because of the music he listened to. It became apparent that the music was currently popular for teens, although the practitioner could join with Ms. Peterson that it certainly might seem distasteful to adults. Listening to such music was normalized as a fairly typical teenage behavior rather than being indicative of satanic worship.

**Discussing the Impact of Client Behavior on the Complainant**

Sometimes parents’ negative remarks about their children can be deescalated through the question, “How is this a problem for you?” (O’Hanlon & Weiner-Davis, 1989). When the mother from the above example was asked, “How is his listening to that music a problem for you?” she responded that it offended her. The solution, therefore, became that her son could only listen to that kind of music on headphones; she did not want it blasting through the house.

In another example, Mr. and Mrs. Boccio complained about their nine-year-old’s “bad” behavior and how he never listened to them.
When pushed to be more specific, they said he didn’t make his bed. Both went on at considerable length about this complaint. When they were asked, “How is this a problem for you?” they were stunned into silence, realizing they had made a relatively minor behavior loom exceptio

nally large. The question changed their perspective about the problem, and they started focusing instead on the many positive behaviors their son demonstrated. For the behaviors they wanted him to change, they learned how to be more specific about their requests and to give positive feedback when he met their expectations.

Reframing

Reframing is the process by which the client is given credit for positive aspects of behavior previously seen as negative (Berg, 1994; de Jong & Berg, 1998). For example, the practitioner reframed Ms. Jackson’s complaints about her grandson not talking enough and not listening: “He is quiet, but I’m sure he is listening a lot.” Through reframing, clients are able to choose new meanings that are more conducive to change.

Another way to use reframing is to align family members’ goals. For example, with teens, the parent will usually want the child to perform certain chores and duties without arguments. The teen may want to have freedom with less parental nagging involved. In these cases, the problems can be reframed as a similar desire to get along, with the teen taking more responsibility, and in exchange, parents granting more freedom.

Problems can also be reframed in a way that make the issue more amenable to solutions. For instance, Nicki, a 17–year-old teenager with a new stepmother kept saying, “She’s not my mother. She can’t tell me what to do.” She also complained that her father and new stepmother were treating her like a child. (With only her father and herself, she tended to play more of an adult role.) The teenager said she just wanted to leave home and be by herself. The practitioner said if she was planning to leave home soon, then she should practice having roommates. If she saw her stepmother more as a roommate, how could they work this? The teen became more engaged on how roommates have to get along to keep the living arrangement running smoothly with each person having responsibility for keeping the apartment clean.

Aligning With Client Goals

The solution-focused practitioner works on aligning with client goals (Berg, 1994; Bertolino & O’Hanlon, 2002). Therefore, the practitioner must align with the parent’s view, that the focus should be on the child’s behavior problems. However, solution-focused therapy also has a systemic basis and considers the context of behavior. Part of the beginning process, therefore, will be engaging parents in playing such a large role in the treatment process when their expectations might have been different, that their child would be seen alone as a focus of treatment time (Morrissey-Kane & Prinz, 1999).

One way to engage parents in this process is to stress the importance of parents to their children. (“You are much more important to your child than I will ever be in 1-hr a week sessions. If I can help you deal with your child and you can do this at home, you will be much further along.”) Parents can also be told about the cognitive abilities of young children, that they have a difficult time generalizing behavior learned in one setting to another. Therefore, if parents are present in session and see the new skills their children are learning, these effects can be carried over to the home.

Engaging parents in treatment can also be attained by assuring them that treatment will proceed much more quickly when they are involved, again due to children’s cognitive
limitations. This engagement technique can also be tied to telling parents about how change can be achieved in a brief time frame. Once change is initiated, further treatment may not be necessary, as these will reverberate into other changes in a systemic nature (a child’s improved behavior may lead to a parent viewing their child more positively, which may lead to other improved behaviors) (O’Hanlon & Weiner-Davis, 1989).

Identifying What Parents Want Rather Than What They Don’t Want

When parents catalogue their children’s negative behaviors, the practitioner can ask, “What do you want to see instead?” The practitioner then works with the parent to identify the presence of positive behaviors. For example, rather than “not talking back,” the goal becomes “to follow directions”; rather than “not fighting,” the goal becomes “to get along with siblings.”

In order to keep the interaction alive between parents and children and to clarify expectations, the child is then asked, “What do you hear your mom say she wants you to do?” In many instances, the parent has talked so long or in such a general manner that the gist of the message is lost, and the child is unable to reflect back. In these cases, parents are asked to repeat themselves. Through this process, parents learn to be brief and specific in making their requests.

Engaging With the Visitor Relationship

Children and adolescents with behavior problems usually present with the “visitor” type of relationship (Selekman, 1993, 1997). The child with a behavior problem is engaged in the goal of terminating treatment as quickly as possible with the opening questions: “Whose idea was it that you came here? What do they need to see to know you don’t have to come here anymore?” In this way, young clients see that the practitioner is not invested in a long-term relationship and will work with them on results to get them out of treatment.

Eleven-year-old Rubin answered these questions in the following way:

Practitioner: Whose idea was it that you came here?
Rubin: My teacher, I guess (glances at his mother with a smile). And maybe my mom, too.
Practitioner: What do they need to see to know you don’t have to come here anymore?
Rubin seems a little taken aback by this question and is silent for a moment.
Rubin: I don’t know.
Practitioner: Come on, I know you don’t want to keep coming here. What do you need to do so that they’ll be satisfied, and you don’t need to come anymore?
Rubin: To be good.
Practitioner: What does being good look like?
Rubin: Not fighting.
Practitioner: What will you be doing instead of fighting?
Rubin: Being good.
Practitioner: If I was seeing you through a video camera (mimes this action)—what would I see you doing?
Rubin laughs at the idea but it gets him to think for a moment.
Rubin: Well, in school, I won’t tell the teacher, “No!”
Practitioner: What will you do instead when she asks you to do something?
Rubin: I’ll just do it. I’ll sit there and just do my work.

As in this example, children of all developmental stages have a tendency to answer “I don’t know” to many practitioner questions. The rea-
sons for this response are probably varied: children may honestly not have any idea; some are afraid of giving the wrong answer; some are worried honest answers will upset or anger parents; for some, answering “I don’t know” has been a successful tactic to make people stop bothering them.

There are several strategies to use with the “I don’t know” response. The first is to allow some silence (Berg, 1994). The child may then become uncomfortable and will talk to fill the silence. (Parents should be blocked from filling in the silence themselves.) The silence should not go on too long though as sometimes this turns into a power struggle, which obviously inhibits rapport-building.

The second way to handle such a response is to rephrase the question (Berg, 1994). At this point, the client realizes the practitioner is persistent and will not go away until the question is answered. A third way to handle an “I don’t know” response is to use a relationship question. Relationship questions ask the clients to view themselves from the perspective of another (de Jong & Berg, 1998). This process enables clients to understand the influence of their behavior on others, which is especially important for children with behavior problems who may not see their behavior as problematic to others. Relationship questions also allow clients to view themselves from a more objective position. The child can be asked, “What do you think your mom (or another person impacted by the problem) would say needs to happen so you don’t have to come here anymore?” If the child still isn’t able to come up with an answer, the parent can be asked this same question: “He doesn’t seem to know, mom. What can you tell him about what he needs to be doing so he doesn’t need to keep coming back here?” After parents have given their opinion, children are asked to repeat what they have heard their parent saying to make sure expectations have been clarified.

Exceptions

One of the main interventions for solution-focused therapy is identifying exceptions, times when the problem is not a problem (de Shazer et al., 1986; Selekman, 1993). Once the parent and/or the child identify the desired behaviors, family members are asked about times when those behaviors have already occurred. Usually, people have been so immersed in their problems, they are taken aback by questions about nonproblem times and sometimes are initially unable to answer. Practitioners must allow space (time and silence) for family members to identify exceptions with perhaps additional probing questions if they are still unable to answer. For example, parents can be asked to consider a time when children did chores without parents having to nag. The parent of one teenager, 15-year-old Nikki, said, “She only did the dishes last night because she wanted to go out with her friend.”

Practitioner: Oh, so when she is working toward a privilege she does them without being told.
Parent: She should do them anyway. It’s just what’s expected of her.
Practitioner: Well, what other things does she expect to do without having to work for them?
Parent (starting to catch on): Well, watching TV, talking on the phone.

The rest of the conversation centered on Nikki’s mother figuring out how she could make privileges dependent on Nikki doing what she was supposed to around the house.

If people still struggle, sometimes examples of behavior in the session can be used. For instance, Ms. Jackson complained about Louise not listening and failing to do chores and clean up after herself. At one point in the session, the grandmother spoke sharply to Louise to put a
toy down when the practitioner asked her a question. Louise responded to the reprimand by putting the toy down immediately. The practitioner pointed out that Louise had listened to her grandmother right then. Grandmother then admitted, “Well, she does listen sometimes.” The practitioner could then elicit from grandmother other examples of Louise’s listening behaviors.

Many parents at this point insist the only reason their child is acting properly is due to the presence of the practitioner. Practitioners, of course, can reassure such parents that they have many misbehaving children in sessions, and their mere presence does not necessarily command obedience!

Once an exception has been identified, the practitioner probes for what was different about the contextual details of the situation: who was there, when it happened, what was happening, what thoughts the client was having, how it happened (de Jong & Berg, 1998).

The following dialogue illustrates this intervention with Will, an 11-year-old African American youth, who came to treatment because of fights at school.

Practitioner: Tell me about a time when you avoided getting into a fight.
Will: I don’t know. At school, I guess.
Practitioner: Oh, okay, at school. Where were you at school?
Will: At math class.
Practitioner: Who was there?
Will: This girl.
Practitioner: What was happening?
Will: She was trying to poke me with a pencil.
Practitioner: Then what did you do?
Will: I told her to stop messing with me.
Practitioner: What were you thinking about when you told her that?
Will: That the teacher was watching and that we would get in trouble if I did something back.

Practitioner: Then what did you do?
Will: I turned around and looked at the teacher.
Practitioner: What did she do then?
Will: She was still saying stuff.
Practitioner: What were you doing then?
Will: I just stayed turned around.
Practitioner: What were you telling yourself then?
Will: The teacher was still looking. I wasn’t going to do nothing.

As in this example, some children and adolescents give credit to people or entities outside themselves for exceptions. The practitioner must work to empower clients and help them take credit for the success. One 14-year-old Filipino boy, Kevin, presented with tardiness and skipping school. When asked about exceptions, Kevin identified that when the teacher saw him before class, he didn’t skip. He explained that if he didn’t show up for class after she saw him, he would be caught for sure. The practitioner still insisted on giving him responsibility for this decision: “I know if you really wanted to skip, you could figure out a way to do that. You wouldn’t let the teacher see you. So what does that say about what you can do to make sure you go to school?” He answered, “I guess I can make sure the teacher sees me ahead of time.”

Another teenager talked about skipping school when she saw certain friends. At first, she put the potential solution out of her hands. Her “friends” had a lot of power over her to make her skip. With the practitioner continuing to ask questions, she eventually formulated the solution of avoiding these certain people and seeking out other, more conscientious friends.

**Emphasizing the Context**

When exceptions are identified, details of the context are elicited to include the parent’s role
in the interaction (O’Hanlon & Weiner-Davis, 1989): “What are you doing when your child is behaving?” Parents may realize, for instance, that they had given their children special attention or had remained calm. In solution-focused therapy, the context of a behavior is seen as crucial. Problems do not reside so much as in the individual as in the behavior patterns, which influence others to act a certain way. With child behavior problems, parents play a large role in this context.

**Indirect Complimenting**

Solution-focused writers pay a great deal of attention to complimenting clients and being vigilant for opportunities to praise (de Jong & Berg, 1998). In addition, “indirect complimenting” rather than “direct complimenting” should be used whenever possible and can be directed toward parent or child. A direct compliment is when the practitioner praises the client: “You did a good job” or “I liked the way you said that.” An indirect compliment implies something positive about the client, but pushes the client to figure out the resources used to achieve success (de Jong & Berg, 1998): “How were you able to do that?” “How did you know that was the right thing to do/say?” Compliments are more powerful when clients generate them for themselves. When clients realize their own resources, change begins to occur.

For instance, 6-year-old Louise reported she had folded blankets and taken the garbage out without being told. She was asked, “How did you manage to do that (fold the blanket)?” “How did you know that (taking out the garbage) would be helpful to your grandmother?” Getting Louise to identify the resources she drew on was important not only for Louise to enlarge upon these exceptions, but also so that her grandmother could view Louise in a more positive light. Louise’s grandmother was asked, “How do you manage two small children at this stage in your life?” “What strength do you call on to manage all this?”

To evoke more positive statements from the parent, the child is asked, “What does your mom tell you when you’re doing a good job/doing what she wants you to do?” If a child has difficulty answering this question, parents sometimes realize they have not given their children credit for positive behaviors. When parents praise their children in session, the child is asked to repeat what they have heard their parent say. In this way, the positive message is reinforced and parents begin to realize the powerful effect their words have on their children.

When parents have a more positive view of their children and communicate this to their parents, children tend to increase their positive behaviors, and the relationship between parent and child becomes strengthened.

**Techniques to Help Make Exceptions Concrete**

Young children have difficulty cognitively going into the past to retrieve exceptions (Selekman, 1997). While parents can help them with this process, other techniques are needed to bring the material into more concrete and present focus. Children and even adolescents are able to engage in the use of drawings to make exceptions more concrete (Selekman, 1997). Seven-year-old Tabitha and her mother often argued about Tabitha’s problems getting ready in the morning. These episodes were having a negative effect on mother’s own workday and how she felt about her child. Tabitha was asked to draw the following steps she needed to take in the morning: brushing her teeth, washing her face, getting dressed, eating breakfast, and getting her school supplies together. She was also asked to display, in comic-strip bubble fashion, what she would be telling herself. She wrote in, “I can do it. I can do it on my own.” When asked how her mother would treat her when she was...
doing these things, Tabitha said they wouldn’t be fighting, and her mother would kiss her good-bye.

Another way to make exceptions come alive for children is to role play situations to make concrete the strategies children use in order to overcome their problems. Eight-year-old Rhonda was referred from the school for talking out of turn in class. Her “exception” involved sitting near the teacher, which helped curb her impulse to talk. The situation was role-played with the practitioner, whom Rhonda elected to play the teacher. Rhonda showed herself busily applying herself to schoolwork. In order to help the child draw on all her potential resources, the practitioner asked her to say out loud what she was thinking. Rhonda said, “I need to look at my work and concentrate on what I’m doing.”

The following week, Rhonda reported she had a difficult time putting the plan she had developed into action. The practitioner asked, “What needs to happen so you can remember what we talked about in here?” The girl said she needed to have a physical reminder, so they came up with a symbol on her hand, a T with a cross through it symbolizing “no talk.” After this, Rhonda was successful at implementing her plan.

Parents can also be engaged in role plays with children directing who will play certain roles. Role playing forces members to take on new perspectives, which helps them view a situation differently. The playfulness of a role play also lightens up the negativity that may surround problems and introduces new possibilities for behavior.

**Homework on Exceptions**

A common formula task for the first session prescribes for family members to take note of “all the things that are happening that you want to have continue to happen” (e.g., de Jong & Berg, 1998; O’Hanlon & Weiner-Davis, 1989). Through this assignment, parents and children are directed to further focus their attention on nonproblem times and the resources that are being drawn upon.

**An Emphasis on Exceptions in Subsequent Sessions**

In subsequent sessions, practitioners can start by posing the question, “Tell me what is better” (Berg, 1994; O’Hanlon & Weiner-Davis, 1989). Despite the positive orientation of this question, sometimes parents still try to catalogue their children’s transgressions from the prior week. Rather than allowing the session to be taken over by “problem talk,” the family can be reoriented by asking “How could the situation have been handled instead?” This discussion could also be followed by a role play so that new behavior choices are made more concrete. This process is much more productive than spending time with a family going over in detail problems that have already occurred.

**Externalizing**

Exceptions can further be identified through a narrative intervention called “externalizing the problem” (White & Epston, 1990). Externalizing the problem involves a linguistic separation of the presenting problem from the person. Instead of the problem being one of personal dynamics and an inherent quality, it is seen as an external entity.

Young children can be requested to draw the externalized entity. For example, if a child is being seen for anger problems, he or she can be asked, “What do you want to call the anger?” Common responses are “the volcano” and “the tornado.” Children are then asked to either draw this externalized entity or to draw themselves taking control over it. Questions are asked about times when they have control over the volcano,
when it has control over them, and the strategies they enact to gain influence over their behaviors.

School-age children still may enjoy playful names for the externalized objects. Eleven-year-old Rubin was seen for various problems at school, including not completing work, defying teacher instructions, teasing others, etc. He was asked, “What do you call all that stuff you do at school?” He answered “the crap” and thoroughly enjoyed his practitioner and his mother referring to “the crap.” The sense of playfulness generated by the constant references to “the crap” decreased the seriousness of the problem, and seemed to reduce his need to engage in these behaviors. Both the client and his mother reported that school referrals over “the crap” had reduced dramatically.

Another example of externalizing is illustrated with 16-year-old, Connie, who was on probation for marijuana use:

Practitioner: How have you resisted smoking pot in the past?
Connie: Thinking about my UAs (urinalyses) and about what’s going to happen if it’s positive again.
Practitioner: Okay, that’s smart and logical thinking. What else helps you resist the urge to smoke? (externalizing)
Connie: Occupying myself. Doing anything but sitting at home. But then, whenever I go to parties, and I’m not sitting at home, it’s there.
Practitioner: What else would help you resist then? (externalizing)
Connie: Thinking about how I’m going to fail, and I want to finish the semester.

Externalization enables clients to take a less serious approach to their problems, freeing them to come up with options, and thus, empowering them to “fight against” their external oppressors (White & Epston, 1990).

Externalizing is particularly useful when parents come in with diagnostic labels to describe their children’s problems even when there is no medical basis for these claims (Bertolino & O’Hanlon, 2002). From the popular media or other mental health professionals with whom they have worked, some parents have become facile in using such diagnostic categories as attention deficit hyperactivity disorder (ADHD) or bipolar disorder. A child can be asked an externalizing question around this label, such as, “When are you able to stand up to the ADHD?”

Seven-year-old Hector identified that when he did his homework on the computer rather than by hand, it was more like a game, and he could concentrate longer. Parents can also be asked how they can work with their children to stand up to the ADHD, to not let it take over. Ms. Gomez said rather than making Hector keep working on his homework past the point of frustration, she would let him take a break. After 5 min of playing Nintendo together, he then could attempt to tackle the homework again.

In another instance, Mrs. Garret, the parent of 14-year-old Ed, claimed her child was “manic depressive.” However, she was unable to explain the source of this diagnosis or why her son wasn’t on medication. She also didn’t follow through on a referral for a psychiatric visit for her son. When he would start to argue with her, Mrs. Garret would say, “There goes the manic depression again.” He even said, “I wish I could have normal kid problems rather than manic depression.” It was normalized for this mother that teenagers often argued with their parents to get what they wanted, especially if this tactic worked. The mother admitted that when her son argued with her, she would eventually back down. It was easier for this mother to blame the interaction pattern on his “manic depression” rather than her giving in to his arguing. The mother was instead asked an externalizing question, how she could resist his invitation to debate with her, and the work focused on that instead.
Scaling Questions

Scaling questions involve ranking progress on goals on a 10-point scale (de Jong & Berg, 1998). Although scaling questions are primarily used for goal setting, multiple interventions can follow with this technique. Scaling questions begin when family members are asked to identify the priority goal. Solution-focused therapy centers on client-identified goals. The goal should be achievable (rather than perfection), limited to one setting (i.e., home or school), and involve the presence of concrete behaviors rather than the absence of negative behaviors. After the concrete indicators are formulated, the child is asked to rank order current functioning on the scale. The child is then asked a series of relationship questions around his or her parents’ positions: “Where would your mother say you are? Where would your dad put you?” Relationship questions can also involve other people interested in seeing the child’s behavior problem resolved (e.g., teachers, probation officers). The parent(s) present in the session can then give an estimate of the child’s current functioning in terms of the scale. Any discrepancies between the child’s suppositions and the parents’ actual ratings can then be explored.

The scales pose an advantage in terms of helping parents view their children in less dichotomous ways. Sometimes parents will initially discuss at length their children’s negative behaviors and will resist attempts to look at strengths. However, when they are presented with the scale, they will often rank their children more highly than would be expected from their previous complaints. The scale gives them a concrete reminder that there are plenty of examples of appropriate behavior. For example, Louise’s grandmother spoke negatively about Louise’s inability to clean up after herself, her lying, and inability to remember instructions. However, Louise was ranked at a “seven” by her grandmother on a “chores” scale.

More discussion on exceptions can develop from the rankings on the scale (de Jong & Berg, 1998): “Wow, you’re already at a five. You’re already halfway. What are all the things you’ve been doing to make it so far already?” “A two! You’ve already taken some steps. What have you been doing?”

Task-setting follows from the scale by asking children, “What needs to happen so that you can move one number on the scale before next time we meet?” Even young children easily grasp the ordinal nature of the scale and often find moving up on the numbers quite reinforcing in itself. Children often proudly come into subsequent sessions, announcing how they have advanced on the scale. Progress is tracked over time so the scales serve as measures of goals. Scales make goals and the steps necessary to attain these goals concrete and specific (Murphy, 1997).

Conclusion

Youth below the stage of formal operations may experience difficulty bridging the past and the future in the way solution-focused therapy demands. Therefore, the identification and enlargement of exceptions and the application of nonproblem behavior to future situations will have to be made more immediate and concrete in session. Through the adaptation of techniques, solution-focused therapy can be used effectively for children of all developmental stages (Corcoran, 2001), and so that both parents and children are active participants in the therapeutic process.
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References


