Case Study

MR. SPOCK GOES TO THERAPY

GOOD THERAPY MEANS KNOWING WHEN TO BREAK THE RULES

Eve Lipchik

Much attention has been focused on the straightforward and easy-to-learn techniques of solution-focused therapy: questions about times when the problem is less intense ("exceptions"); questions about hypothetical solutions ("miracles"); and questions about the quantitative differences between problems and exceptions ("scaling"). Yet despite the seeming effectiveness of these techniques, when clients are asked to explain why they feel better from one session to the next, they often refer in general terms to feeling accepted and understood by their therapist—a mark of all good therapy, regardless of orientation.

So rather than emphasizing technique when training therapists, I focus on the theoretical assumptions that lie at the heart of the solution-focused model. These include: Change is constant and inevitable; a small change can lead to bigger changes; since you can't change the past, concentrate on the future; people have the resources necessary to help themselves; and every human being, relationship, and situation is unique. By relying on these assumptions as a guide to what to ask clients next and how to respond to their answers, therapists are freed from their anxiety about "doing the model" the right way or whether a particular case is appropriate for this approach and can focus, instead, on attuning themselves to their clients' reality and developing a sense of timing that fits each case.

The following case illustrates the overarching importance of setting aside rigid orthodoxies and breaking the rules to meet a client's idiosyncratic needs.

When Lyle first walked into my office, he seemed a shy and sensitive man who wasn't sure he wanted to be there. Tall, well built though slightly overweight, he was neatly dressed, with a small gold hoop in his left ear. At 27, Lyle had recently moved to Milwaukee to "make a fresh start" after six years in the Navy. During the six months immediately

following his discharge, Lyle had returned to his home town on the West Coast and had confided in his mother and a few very close friends that he was gay, but had asked her not tell his father, two older brothers, and an older sister. He had also had his first romantic encounter with a man, which had ended in their being friends but no longer lovers. To Lyle, life in Milwaukee was lonely and unexciting. Trained as an inhalation therapist in the service, he now worked the evening shift in a hospital, where he had met his only social contact, a nurse named Nancy. Nancy and her husband and child were Lyle's "family away from home." Concerned about Lyle's depression, it was Nancy who had urged him to seek professional help.

Despite his apparent discomfort, Lyle seemed eager to tell me his story, as though he had rehearsed it before coming. He said he did not feel at all settled in Milwaukee and felt like an outsider at work. He agreed with Nancy that he was depressed; in fact, he believed he had been depressed since his grandfather had died when he was eight. All he felt now, he reported, was anger, sadness, and very little else—except "when people are listening to me and accepting what I have to say as a viable point of view." When I tried to get him to expand on this exception, he tensed up and began answering my questions with "I don't know." An attempt to get him to scale his negative feelings in relation to his positive ones met with the same fate. The closest he could come to quantifying anything was to say that he would like his ratio of positive to negative feelings to be 50/50.

Since I put a lot of emphasis on the emotional climate in which the collaboration for solutions takes place, I took Lyle at his word about feeling best when people listen to him. I asked him what he thought would be most important for me to hear. The question seemed to relax him, and he began to talk effusively about his sense of emptiness, a lack of feeling that he thought related to the childhood experience of being removed from his grandfather's funeral because he was crying so hard. His way of coping over the years had been to try to emulate Mr. Spock, the Vulcan on *Star Trek* who was incapable of human emotion.

"Are you sure you want more feelings, even positive ones," I asked him, "or do you want to work on being more like Mr. Spock?"

"I want more positive feelings," he insisted, but then proceeded to recount all his negative ones in detail. Once again, Lyle seemed to be

trying to tell me how bad he felt, which prompted me to check for suicidal or homicidal ideations. He admitted that suicide had crossed his mind at times, but he had never made any suicidal gestures and did not seem to have a plan in place. In an effort to move from problem talk to solution talk, I tried to focus more on how Lyle had managed to cope with his difficulties. This opened a floodgate of self-recrimination. "I haven't dealt with life. I've avoided it!" he said in disgust. I offered another perspective by saying that some people might think that he had coped well given his painful life. After all, he had finished high school and a year of college, he had spent six years in the Navy, had learned a profession there and had been honorably discharged, and he was now holding a job. He dismissed all of this with the comment, "If I don't function, I don't get things. I do it for me because no one else will." I wondered aloud whether his ability to do this could be thought of as a strength. Lyle seemed startled and said, "I never looked at it that way. I always thought it was fear that kept me going."

An important piece of the solution-focused approach is the summation message, which the therapist composes, alone or with a team, during a break about 40 minutes into the session, then presents to the client at the end of the session. It is a way of reflecting back, of supporting and reinforcing positive gains and offering new perspectives. This was my summation message to Lyle after our first session:

"What I hear you say today is that you are here because of your depression, which you remember as starting when your grandfather died. You say that you feel a lot of angry and sad feelings but little happy or positive ones. Your goal in coming is to feel happy feelings about 50% of the time.

"My response is that you appear to be a thoughtful, conscientious person who is very sensitive to what others think and feel about you. It seems pretty natural that you have a lot of anger and sadness, given your feelings that your parents did not validate you and that you lost the only person in your life who did. It was really creative of you to look to a fictitious character like Mr. Spock as a role model, yet you have managed to grow up and appear to be a much warmer, more human man—more like the grandfather you described to me. It seems to me to be a good idea that you took your friend's advice to come to talk to someone. That is a sign of strength. Since you have such high standards for yourself, I

hope you don't expect to develop new habits about feeling more positive very quickly. That takes time and works better if one goes slowly."

I then casually suggested to Lyle that he might spend 15 minutes once or twice each day writing about his negative feelings and then destroying what was written—a technique I often recommend to people who are putting pressure on themselves to change. I added that it would help me to understand him better if he would continue keeping track of any positive feelings he experienced, no matter how small.

When Lyle returned a week later, he looked sad and sullen and told me right away that he had not acted on any of my suggestions. I knew immediately that I was being tested. Lyle was asking, "Will you listen to me and validate me, no matter what I do?" Choosing not to respond to this tacit question, I asked whether there was anything he wanted to share with me about what had happened since last I saw him. He shook his head. When I asked, "Were there any questions you wish I would have asked you?", he perked up and reported that he had generally felt more hopeful this week. He had felt more focused and productive at work and had been more relaxed with the people there. All his examples were described in feelings; he refused any behavioral focus. When I tried to get him to talk about a future in which these positive changes could be maintained and increased, he responded by telling me self-denigrating stories.

Ventilation—or problem talk—is certainly not a solution-focused technique, but I realized that if I did not allow Lyle to set the tone and pace of our conversations, he would probably not come back. At one point, I said, "I know this is very hard for you, and you want me to understand how much pain you felt in the past. I don't mean to discount it, but the past is gone, and you came here to talk about happier feelings. Is this helpful, or do you want to talk about how you can feel differently in the future?" Lyle kept right on ventilating. What was I to do? Clearly, he needed me to accept and affirm him just the way he was, yet I didn't want to encourage his problem orientation. Even when I tried to use his grandfather as a resource and asked him to consider what his grandfather would say about something he put himself down for, I could not get a more positive focus.

In keeping with the adage "brief therapy goes slowly," I chose to be patient and empathic, while listening for an opportunity to shift the

conversation. Finally, after he had inventoried complaints against his parents and against himself for poor choices he had made as a child and adolescent, I interjected, "As an adult you seem to have a much better understanding about how to relate to people than you did when you were younger." Lyle relaxed visibly, took a deep breath, and slowly joined me in talking about future change.

In the summation message for this session, I reflected back my understanding of Lyle's angry and sad feelings about his past. I commented on how hard he was on himself and reinforced the idea that he could reevaluate his feelings from an adult perspective. I also suggested that he might consider how the qualities he remembered in his grandfather might prove useful for him as an adult.

The next three sessions took place one week apart and followed a distinct pattern. Lyle would describe some small changes, then immediately begin venting negative feelings. The positive changes were consistent and significant, so I just kept doing what was working. At the same time, I found many opportunities to challenge Lyle's belief that he had to keep feeling the same way about things now and in the future as he did in the past.

As our conversations progressed, Lyle's ventilation turned to more intimate issues: his sense of being different because he was so angry much of the time; his belief that he was inherently bad; his premonitions about future events; his escape into daydreams and fantasies. I heard them all as one loud, fearful question: "Do you think I'm crazy?"

I addressed this tentatively by reflecting how difficult it must be to live with so many concerns about oneself and asked whether he had overcome any worries from the past. He answered, "No, I'm still not that human." He went on to tell me about his tendency to sit in a daze and not really hear what people were saying to him. I wondered whether he was talking about our conversations and decided to check it out—not because I was interested in exploring the transference, as a psychodynamic therapist might, but because I wanted to be sure that I was truly hearing him the way he was hoping to be heard. Lyle acknowledged that he sometimes felt dazed with me as well, but added, "I know what's expected of me, and I have to respond. I'm rising above my feelings to help myself." Again Lyle was indicating that he had some

control over his feelings, which I reinforced by asking, "How is talking with me giving you the control to rise above your feelings to help yourself?" "There are times now when I'm more awake," he offered tentatively. "Then I handle things better."

By the fifth session, Lyle was still not ready to accept compliments when he reported positive changes or to expand on them in response to my questions. Instead of stonewalling me, however, he was now able to share with me what was on his mind. "If I keep reminding myself that I'm doing well," he explained, "an internal voice will scold me for bragging, or I might worry that I'll end up letting myself down." I wondered aloud what was worse, always feeling bad about oneself or letting oneself down once in a while. "I would choose feeling worse any time to letting myself down," he answered emphatically.

Now my own internal voice chimed in with a concern of its own. "Does this mean he can't allow himself to get much better?" Given this dilemma, I asked how he thought our conversations could be helpful to him. Lyle explained that I represented an unbiased viewpoint that he could allow himself to consider. "But I would think some people might still choose to discount it if they preferred the option of feeling worse," I responded. "No," he said. "Because it is a professional opinion, and that means something. I go home and think about it. It's very slow, but I think I've made some adjustments. I need to begin to do other things on the outside to help myself, and I'm starting to do that."

Since he recognized there had been change, I asked him to scale the difference between how he felt about himself when he first came in and how he felt about himself now, but again he would not cooperate. In retrospect, I realize that this technique did not fit with what he had just told me about being afraid to acknowledge too much change. In one of our later sessions, when he was beginning to acknowledge progress, Lyle spontaneously noted that the change had improved from 5% to 15%. When Lyle observed that progress was good but slow, I suggested that we meet every other week so he could continue to move slowly and not feel too uncomfortable about change. He agreed.

In the sixth to eleventh sessions, Lyle continued to report progress. Although he still started by talking about the positive and then shifted to complaints, the positive talk was getting longer and the negative talk

shorter. The positive talk focused on professional and social successes. For example, when he was invited to attend a wedding back home, Lyle asked an old friend to accompany him so he wouldn't feel lonely and isolated. In my summation message for one of these sessions, I suggested that Lyle might consider doing an exercise in which he practiced distinguishing between what pleased him and what pleased other people. To my surprise, he actually followed through on the suggestion. It was a new idea for him to distinguish what he wanted from what someone else might want, he admitted.

One of the goals of solution-focused therapy is to help clients access and build on their own resources. But what if the client's resources are deficient in some areas? Lyle, for example, seemed to think that identity was a fixed set of characteristics. He was surprised by the idea that one could have an identity yet still make different choices in different roles with different people. "From what you have told me about yourself," I observed, "your identity has been shaped to a great extent by choices you have made, like whether to conform in the Navy or get kicked out. Whether to go to work and do what is expected of you there." "Then I guess I'm the type of person who sits and won't do anything because I'm afraid of what people think," he responded.

"That may be one aspect, but it isn't your whole identity," I countered. "Isn't who you are also the loving grandson; both the loving and the angry son; the sometimes pompous and authoritarian inhalation therapist who is always sensitive and caring with patients? Aren't you a unique combination of all these qualities?"

This perspective seemed to disturb him because it represented uncertainty rather than stability. Gradually, he seemed to begin to recognize that choices did not have to be either/or and did not always guarantee a positive outcome because of other people's choices. We talked about his power to make choices in the future based on his own values and how he wants to feel about himself. This seemed to take on greater meaning for him when I reminded him that Mr. Spock had not been free from making choices even though he had no feelings. As he began to understand this new perspective, I noticed that he gradually became more accepting of himself when he talked about being both "arrogant" and "warm" at work under different circumstances.

The eighth session veered from the usual pattern. Lyle started out by telling me that he had been so depressed during the past two weeks that he had almost packed up and moved back to the West Coast. As he vented about how lonely and sad he felt, I recognized this as a positive change and asked what had kept him from acting on his feelings and leaving. I also wondered what was different about this depressive episode than past ones. Without hesitation he said it had been less intense than previously because he never even thought about suicide. He then began to wonder whether perhaps he had just been lonely and homesick, and not depressed. Nancy and her family had been out of town and he had missed them. He also received a letter from home about his dog, whom he missed. I normalized his feelings and he replied that, given that this was his first experience living without parental or military supervision, "life here isn't all bad; I like being on my own."

After this session, Lyle's mood lifted, and it seemed appropriate to evaluate where we were. How many more positive than negative feelings was he experiencing? Although he did not want to scale his answer, he indicated that he thought he had made a lot of progress. He cited being more assertive at work, extending himself more socially and feeling generally more courageous. As he neared his original goal of having more happy feelings, however, he had begun to realize that his real goal was to have a satisfying relationship with a man. "But that feels like a lot of pressure," he added quickly. I suggested he go slowly after all the changes he had been making, and we set an appointment for three weeks later.

At this next session, Lyle focused almost exclusively on positive changes. He joyfully reported receiving a promotion at work and feeling really good about himself. He was even coping well with coworkers who felt jealous of him because they had been passed over. "I'm making choices for myself that work for me," Lyle said. Most important of all, he had come out about being gay to his father, writing a letter to both parents so his father would not suspect that his mother had known all along. To Lyle's tremendous relief, his father had phoned immediately and had been very supportive and accepting. At the end of the session, Lyle said he had been feeling like a normal person lately and had been enjoying more "ups." Lyle's only concern was that he had been waking up at night crying. When I asked him what he thought it

meant, he said he was crying because he wanted a love relationship but was afraid of it as well. I also sensed that he might be releasing some of the sadness and grief he had kept inside for so long.

In my summation message, I reflected that he had been talking about so many losses since our conversations had begun—the loss of his grandfather, his home town, his childhood, his identity as a military man, his identity as a straight man. I wondered whether he might need time to grieve before he moved on to the new challenge of finding a relationship.

Three weeks later, Lyle seemed anxious and sad again. While acknowledging that he had met his goal, he worried about crying in his sleep and about some recurrent daydreaming. It seemed natural to me that he was presenting more symptoms at this time. Quite possibly he was feeling conflicted about giving up his relationship with me, and he might also have been trying to avoid talking about his longing for a love relationship. I decided to respond as I had in previous sessions when he was anxious—by giving him control over what we talked about. At first he seemed uncertain about what to say, but finally he shared that he had been putting pressure on himself to do things he was not yet ready to do. He had concluded, however, that he did not have to see it as one way or another. He could take a break from therapy now and consolidate his gains without added pressure. True, he was still lonely for a partner, but he had begun to consider Milwaukee his home, he saw himself as successful at work, he had expanded his social circle somewhat to include some women at work, and he felt more secure with his family relationships. I invited him to come back any time and suggested he could set up an appointment for four to six weeks later, but he chose to leave things open. I complimented him for recognizing his needs and knowing when to allow himself rest and when to push himself to grow.

When Lyle left, he walked quickly and did not look back, rather than lingering, as he had done in the past. I felt sad that he might be feeling pain at the loss of our relationship. But I knew that continuing our sessions would have compelled him to face what he clearly wasn't ready to face: the anxiety of finding a love relationship. I trusted that he would be able to rely on his own resources now, and I hoped that our conversations had been helpful enough that, when he was ready for the next step in his life, he might consider talking with me.

Solution-focused therapy is guided by the client's goals, not the therapist's agenda. It is useful and appropriate for clients who are motivated to make dramatic changes as well as those who need ongoing support for life situations that realistically may not ever change, such as people dealing with problems of aging, chronic physical illness, or developmental disability. Most of all, the solution-focused therapist must develop a sensitivity to the timing and pacing required in each individual case. Going very slowly at first, in order to really be in sync with the client's view of things, may lead to a quicker solution in the end.

CASE COMMENTARY 1

BY BILL O'HANLON

I can't stand to watch soap operas on television. It seems I'm always yelling at the screen, frustrated that the characters won't take simple, obvious steps to avoid the messes they are about to get in. Julie is about to marry the big-city attorney Barclay Clay (the III), and she thinks perhaps she ought to tell him about the child she had out of wedlock with the Vietnam vet drifter who came through town a few years back and is now being raised by the family down the street. She is just about to spill the beans when the phone rings. But when she gets off the phone, she chickens out and doesn't tell him. "Tell him!" I yell at the screen, "It will save us five episodes in the future." I know, and so should she, I think, that during the wedding, the little kid is going to come running down the aisle, after having just learned that Julie is his biological mother, screaming, "Mommy!" for all the shocked congregation to hear. Or the Vietnam vet will return and begin to blackmail Julie to keep quiet about the child, and so on, and so on.

I had the same feeling reading this case example by Eve Lipchik. I've seen Eve work and know her to be a good, respectful therapist who has lately been trying to expand the formerly narrow boundaries of solution-focused therapy. She stresses the importance of being flexible with clients rather than focusing solely on solutions.

In this case, I kept wondering why it took her so long to drop the rather rigid formulaic approach that characterizes much of solution-focused work, which some critics have jokingly called solution-*forced* therapy. Although the proponents of the solution-focused approach claim that anyone doing solution-forced therapy isn't practicing the model correctly, if you watch some of the students of this method doing therapy, you will find a formulaic approach in action.

If one of the assumptions of this method is that every human being, relationship, and situation is unique, why did Eve choose to persist in a method that was clearly not meeting the client's needs for so long? Since this client indicated in the first interview that scaling questions weren't helpful, why should he have to keep answering such questions in future sessions? This is a setup for soap opera drama between client and therapist: He becomes resistant; she redoubles her efforts to get him to answer scaling questions.

The crucial element missing in this case from the beginning was finding out what the client actually wanted to change. Too quickly, the goal of therapy became narrowed down to "feeling happy about 50% of the time." I would have thought that the client might want something like finding more friends, a change in his sense of emptiness, to talk about what would constitute dealing with life instead of avoiding it, or to discuss his gay sexuality and his coming out process, his tendency to sit in a daze and not hear people, and so forth. I'm not sure if any of those or something else would be more compelling for him, but "to feel happy about 50% of the time," didn't seem to resonate with this guy. (It also wouldn't resonate with many managed-care companies.) What Lyle's actual goals might be are uncertain from the case description, but again, rushing to impose goals prematurely is a setup for a soap opera.

The pattern of adhering to the model instead of responding to the client runs through the case description. Throughout, when Lyle expresses negative feelings about himself, Eve consistently tries to reframe him out of these feelings. She continues to give him compliments (another solution-forced method) until he finally lets her know that when he tries to do the same with himself, he hears an internal voice that scolds him, or he feels pressure to

perform up to some standard. Finally, she begins to do what therapists often do when their clients refuse to fit their procrustean bed of theory and method: She doubts the client's motives and real desire to change ("Does this mean he can't allow himself to get better?"). When she asks him about this, he tells her that he does find therapy helpful, because her unbiased view gives him help in considering his life. Immediately she asks him a scaling question (oops, back to the model).

Carl Rogers taught us years ago that listening respectfully to clients and letting them know we can hear their perceptions and feelings and that we accept them as they currently are is a prerequisite for most people to cooperate in the change process. To refer to this pejoratively as "ventilation," as Eve does, seems disrespectful and shows her bias against expressing feelings and the past. But there are many ways to get to solutions. The important thing is to find one that fits for the client, not just for your model.

There's an antidote to solution-forced, structural-forced, psychodynamic-forced, and any other forced kinds of therapy. Get collaborative. You can still have a model, just be flexible: Ask clients what is helpful (Eve does this several times, to her credit) and listen respectfully to them without initially trying to change or mold them in a particular direction. Then incorporate their responses into your therapy.

A hallmark of a collaborative approach is asking *curiosity* questions rather than *agenda* questions. In contrast, when Eve says to Lyle, "I don't mean to discount it, but the past is gone, and you came here to talk about happier feelings. Is this helpful, or do you want to talk about how you can feel differently in the future?", she is saying, in effect, "I know you indicate that talking about the past is important to you, but my model says that you are better off talking about the future."

Clearly Eve, whose work is usually collaborative with a solution-focused flavor, wanted to use this case to highlight the very points that I've been making in this commentary: Be flexible, listen to people, and adjust your interventions based on their responses. Eve keeps having conversations with her model before she has conversations with her client. Our first loyalty must always be to our clients

rather than to our models. When there is a conflict between client and model, always defer to the client. Failing to do so usually leads to bad soap opera rather than good therapy.

Case Commentary 2

BY MICHELE BOGRAD

I appreciated Lipchik's willingness, as a solution-focused therapist, to reveal that many cases using this approach do not have the easy, almost magical outcomes that we often read about or see on videotapes at conferences. Although Lyle eventually made changes, he strongly resisted Lipchik's efforts to have him focus on solutions not problems, on narratives of change not on litanies of failures. In fact, it is ironic that, although Lipchik emphasizes the importance of freeing novice solution-focused therapists from their anxiety about "whether a particular case is appropriate for this approach," the applicability of the solution-focused model was the major question I had about this case.

As a practical matter, few therapists are flexible enough to choose a model for each case that best fits a client's idiosyncratic needs. Instead, most of us (including myself) regularly use the clinical approach we find most comfortable or personally stimulating. Here, as I read about Lyle's passivity and deep sense of discouragement, I found myself wondering whether he would have responded more readily to a different model that paid more attention to his past, his passivity, his deep sense of discouragement, and his difficulty even entering into the therapeutic relationship. Most of us invest a considerable amount of time in training our clients how to work within our model. Such persistence is an important part of establishing the foundation of the therapeutic relationship. But when does persistence shade into dogmatism? Lipchik was indeed tirelessly persistent in applying the premises of solution-focused therapy even as she struggled with Lyle's lack of responsiveness to her interventions. Is her work an example of the dogged attempt to forge a therapeutic alliance or of a

therapist's insistence on a preferred clinical framework in face of a client's desire for something different?

My own work typically focuses on reworking injuries of the past and on analyzing people's premises about life, on the nature of their relationship with me, and on the wider social issues that shape their lives. I believe that change takes time, that the therapeutic relationship is central to healing, and that clients' characteristic ways of being need to be challenged, even as current changes are highlighted and supported. I think I would have made Lyle's ambivalence about receiving help and entering into the therapeutic relationship the initial focus of our work. I also would have focused specifically on Lyle's homosexuality. Lipchik seemed to let Lyle take the lead on his coming out; I would have more actively tried to create a context in which he felt an openness in talking about his hidden world. If Lyle told me that he was not ready to address coming out or didn't find it helpful, I would, of course, have accepted his choice. But I assume that it is my job to take the initiative in helping clients who are part of disenfranchised and oppressed groups to normalize their struggles and to link them with larger social pressures. In this case, I would have tried to put Lyle's feelings of unmanliness into social context and support him in challenging norms of masculinity and homosexuality.

Lastly, I would have tried to hold Lyle in treatment longer. The feeling of wistful concern that Lipchik describes at the finale signals for me that her work with Lyle is not done. I certainly respect clients' feeling that they are ready to terminate or need a break, but I also want my own viewpoint to be part of the ending conversation, knowing that sometimes this kind of exchange can lead to a recommitment to therapy and a deeper level of work.

Our field is marked by a surprisingly competitive, critical, and sometimes disrespectful stance toward the wide range of ways in which therapists work and think about change. When I first read this case, I found it an interesting description of a solid, careful, and thoughtful piece of work by a skilled, self-reflective therapist. But when I realized that Lipchik was moved to write out of her sense that some might find the flexibility of her therapeutic approach controversial, I questioned not Lipchik's work but the state of family

therapy. I felt dismay that a therapist still needed to argue that no model is universally helpful, that techniques should never hold sway over the human encounter, and that human connection is the crucial dimension of the therapeutic enterprise.

Author's Response

BY EVE LIPCHIK

First of all, I want to thank Michele Bograd and Bill O'Hanlon for emphasizing that they realize the point I was trying to make by presenting this case study. I understand the process between Lyle and me as reflecting his struggle between wanting and fearing relationship on any level. My addressing this on the content and process level made him feel I understood him and was the reason he kept coming back and eventually developed some trust. In regard to Bill O'Hanlon's comments about goals, Lyle and I never defined a goal until it became clear to Lyle (in the eighth session) that he wanted an intimate relationship with a man. Yes, I reflected back to Lyle in an early session that he wanted to be 50% happy most of the time, but I did not consider that a goal. Lyle was so uncertain about being in therapy that pressing him for a behaviorally focused idea about the future would have been totally insensitive and would have either increased his depression or caused him to discontinue coming to see me.

I was trying very hard to put Lyle's needs above my chosen clinical approach. I recognized, at one point, that scaling did not fit. The idea that I should not have repeated a question once the client did not show interest in answering it (as Bill suggested) seems very limiting to me and reinforces the false notion that solution-focused questions either work or don't in a formulaic way. My experience is that clients are able to hear different things at different times. Moreover, an unanswered question does not necessarily mean it was not heard. Lyle proved that when he volunteered scaled signs of progress about his changes in a later session.

Finally, I hope no one else found my use of the word "ventilation" disrespectful. I merely wanted to draw a distinction between the

dynamic technique of encouraging ventilation as a means for change in itself and my use of it as a way to maintain a safe, accepting climate in which the client can begin to be open to other perspectives. ■

STUDY QUESTIONS

1. What was Lipchik's goal in using a solution-focused model, and why do you think it did or did not work with Lyle?
2. Do you agree with O'Hanlon that the therapy did not fit the needs of the client? Why or why not?
3. Using this case as an example, discuss how clinicians must strike a balance between adhering to a model and meeting the needs of their clients.