Kahn (2000), offers a five-stage model for conducting Solution-Focused Consultation (SFC), which includes: (1) presession and initial structuring; establishing consultation goals; examining exceptions; helping consultee decide on a solution; summarizing and complimenting. Using this model, as well as other interpretations of a SFC approach, I will now outline my plan for working with Tim.

**Presession and Initial Structuring**

Before my initial session with Tim, I send him a short questionnaire and instruct him to complete it and return it to me prior to our first session. The questionnaire asks the following:

1. Imagine you wake up tomorrow and the challenges that you are seeking help with have miraculously improved, how would you know that the situation is different?
2. Who else would notice this difference?
3. How would they know the situation is different?

According to Kahn (2000), the use of a presession questionnaire both provides information about the consultee and how they conceptualize the situation, and it orients the client towards a new construction of the situation based on how it would ideally look. This not only provides information about the problem at hand, but it also shifts the perspective of the consultee towards what a solution would look like. The Miracle Question serves as an excellent tool for gathering this information and shifting the client’s perspective towards solutions (Brown, Pryzwansky, & Schulte, 2011).
In addition to sending Tim the questionnaire, I encourage him to consult any other stakeholders in this situation, such as the counselors he supervises or their clients, to get their perspective on the answers to this questionnaire as well (Paull & McGrevin, 1996).

Finally, I request that our first session begin with Tim orienting me to the organization, his role and duties, any coworkers that are involved in the situation at hand, and any other people or aspects of agency that might be useful in helping me grasp a keen understanding of the situation at hand. The goal of this orientation is to create intersubjective compatibility between myself and Tim, which includes acquainting one another with necessary terminology and creating faith within the client that I adequately understand the situation at hand (Brown et al., 2011).

**Establishing Consultation Goals**

In our first working session together, Tim begins as planned by orienting me to his role as clinical director. He explains to me his duties and walks me through a typical day and typical week. I ask Tim what he believes his strengths to be, and he says (a) his 20+ years of experience and (b) his ability to be flexible and supportive of the clinicians he supervises. I ask Tim if it would be alright if I ask some of the other people I meet in the agency what they perceive Tim’s strength’s to be, and he agrees (Paull & McGrevin, 1996). We then proceed to tour the facility, during which time Tim describes the various programs of the agency and introduces me to the clinicians that run these programs. I ask all of the clinicians that we speak with what they perceive Tim’s strengths to be as clinical director. Nearly all of the clinicians express that it is Tim’s vast knowledge of the agency and the addictions field, as well as his approachability, that characterize Tim’s strengths.
Again, the goal of this initial work is to both adequately inform me of the situation and empower the client (Brown et al., 2011). Specifically, my inquiry into Tim’s perceived strengths is a direct attempt to help Tim see that he already possesses the resources necessary, namely his knowledge, communication skills, and demeanor, to improve upon the situation at hand (Triantafillou, 2011).

Next, we look at Tim’s answers to the questionnaire. For the first question (The Miracle Question), Tim stated that he would know the situation was different because of two indicators: (1) fewer clients would be entering MET from IOP, thus indicating that they were progressing through the IOP program appropriately, and (2) clients in MET would progress to RPT or be discharged from services more quickly, thus demonstrating the efficacy of MET. Tim says that both clients and counselors would notice this change. The clients would notice that they are progressing or would be forced to confront their own lack of motivation for participating in the agency’s programs. The counselors would notice, because they would feel like acceptable numbers of clients are having success and that they can handle their caseloads.

Tim goes on to say that he ran the questionnaire by all of the counselors leading IOP and MET programs. Interestingly, a few themes seemed to emerge. First, most of the counselors said that their groups would spend less time checking-in and processing and more time working on building skills and going over the pre-determined lesson for that group. Second, most of the counselors also said that they would be provided with more in-depth ideas and materials for how to cover the pre-determined topic of each group. Third, nearly all of the counselors noted that they would feel less “drained” after group.

From the information provided through the questionnaires and our working assessment of the situation, I assist Tim as he formulates goals that seem in-line with the outcomes he is trying
to achieve. I encourage Tim to begin with small goals and solutions and build upon those as we go (Paull & McGrevin, 1996), making sure that the goals and solutions come from Tim, not me.

Tim’s goals are:

1. Ensure that all MET and IOP clinicians understand the different programs, how they are similar and different, and why.
2. Ensure all of the clinicians are familiar with, and have, the necessary resources and materials to lead their programs.
3. Ensure that all clinicians feel able to successfully lead their programs.

**Examining Exceptions**

At this point it, Tim states that he feels good about his goals but that he also feels like he needs more information about his clinicians’ experience, as well as that of their clients. Tim states that he thought he understood his clinicians, their competency, their challenges, their strengths, and what the work they are doing looks like, but now he realizes that he knows much less about these than he once thought. I ask Tim what he would like to do about this, and he states that he would like to observe his clinicians leading groups and to talk to them, individually and as a group, about the issues present in his goals.

I support Tim in his choice to seek more first-hand information, and I encourage him to both think of, and look for, exceptions—instances when or people who seem to defy the problem and are successful in the ways the goals seek to accomplish (Kahn, 2000; Paull & McGrevin, 1996). I instruct Tim that these exceptions can be an excellent source of information about
potential solutions and encourage him to take note of these. We agree to meet again in a week’s time to examine what Tim has discovered and to work on solutions.

Helping Consultee Decide on a Solution

At our next session, Tim is very excited, because he believes that he has successfully identified important exceptions and factors in the situation. He discovered that most of the clinicians were struggling more than he realized with their MET and IOP programs. Specifically, he noticed that these groups seemed to be dominated by client sharing and processing that, while potentially cathartic, did not seem to substantially benefit the group. Tim identified one major reason this was happening was due to the fact that check-ins often went on far longer than necessary. Furthermore, the topics and lessons of group were getting cut short, because there was so little time left to cover them. Tim also received feedback that check-ins were often allowed to run on, because the clinicians felt ill-equipped to fill the required time with lessons pertaining to that day’s topic.

Tim was able to identify two clinicians who seemed to be exceptions to the problem, and he noticed that both of these clinicians were well prepared in advance, monitored time well, maintained the structure and flow of the session, and held clients accountable to the group rules. The overall effect, according to Tim, was that these clinicians seemed to maintain a far more structured experience and program.

After talking with his clinicians, Tim also discovered large gaps in the clinicians’ understanding of the agency’s programs, what they are intended to look like, and how they are different from one another. He also discovered that the clinicians know the different
predetermined topics of their groups, but feel very ill-prepared in delivering effective lessons on the topics.

Finally, Tim noticed that some of his clinicians, particularly those seeming to struggle the most, were falling into an authoritarian role. Tim also noticed that these clinicians seemed to use Motivational Interviewing the least effectively. Tim and I discussed the dangers of these clinicians taking a punitive role versus a supportive role and agreed to include this in our solutions as well (Joe, Simpson, & Rowan-Szal, 2009).

From our discussion of Tim’s observations and research, Tim developed the following solutions:

1. Provide his counselors with further education on how to structure lessons and manage time in IOP and MET group.
   a. Highlighting that these are psychoeducational groups, not processing groups, and why this difference matters.
   b. Providing strategies for monitoring time and sticking to topic despite challenging clients.
   c. Empowering clinicians with strategies for enforcing group rules

2. Work with his counselors to revise the lesson manuals for IOP and MET
   a. Making sure the topics are clear and understood by counselors
   b. Working collaboratively with counselors to include plenty of literature, activities, and discussion topics pertaining to each lesson so as to effectively fill the necessary time.
   c. Creating a system for continually adding ideas and resources for executing the different lessons
3. Ensure that all clinicians are using Motivational Interviewing competently
   
a. Taping, coding, and reviewing sessions with clinicians
   
b. Providing additional training where necessary
   
c. Focusing on being supportive and accepting rather than punitive and judgmental

**Summarizing and Complimenting**

Throughout our work together, I make a point to be continually supportive and complimentary of Tim and the work that he is doing (Kahn, 2000). I do my best to point out the obvious strengths in his character and decisions, and I do my best to be consistently supportive of his choices. The real goal here is to empower Tim (Triantafillou, 2011). We complete our work together at this point by recounting our journey and highlighting Tim’s choices, offering positive feedback where applicable.

Tim and I agree to meet again in three months to assess the situation once again and potentially repeat our process if necessary (Kahn, 2000).

References


