Solution-Focused Case Management
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Solution-Focused Case Management

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Joel Simon, MSW, ACSW, BCD
To my wife, Julie, and my daughter, Gianna, for your presence in my life and the joy and support you share with me. To my mom, Viv, and my dad, Carl Blundo, whose love and support are still with me. To my brothers who shared the ordeals of Vietnam and to all those who perished so early in life. —Bob

Once again, dedicated to my wife, Joanna, who is the reason that the past 44 years have been my most rewarding. Also dedicated to the newest member of our family, Lily Jean. —Joel
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I remember clearly my undergraduate days of 40 years ago, when the principles of psychoanalysis and behaviorism were the major theories of the day. We were taught by well-meaning professors that although these “schools of thought” were in contrast to each other, they were the mainstay of our field. Over time, the cognitive behavioral school evolved and we were instructed to “understand the history and systems of all three major schools—and then align yourself with one.” This need for allegiance to a theoretical school continued into graduate training. In fact, you were encouraged to choose a graduate school that placed an emphasis on the particular “theoretical school” of which you now considered yourself a member. With this newly found allegiance, a “lens of perspective” was implanted and, now newly trained, you were ready to develop your practice.

Many of us started our clinical careers in institutional settings. I remember my first day, working in a state-operated developmental center. The individuals who lived in that long-term residential setting were primarily classified as “dually diagnosed.” Within this setting, training in behavioral therapy was expected and behavior modification was the treatment modality most widely used.

With the advent of deinstitutionalization, my work focused on providing services to community-based older adults with cognitive difficulties. Again, the emphasis was on behavior modification. However, now there was evidence of a “cognitive approach” sprinkled in.

Over the years, as my agency-based practice continued, my training and experience in “task-centered social work” evolved, and I started to develop a private practice. In my private practice, I saw adults and families within the paradigm of a structured, short-term intervention. I would tell clients at the onset of treatment: “I practice short-term psychotherapy; that is, focused on the here and now. I see clients for 8 to 12 sessions.” For years, I would work with families and feel very comfortable with the Diagnostic and Statistical Manual of Mental Disorders by my side and a theory in my pocket. Then I met Joel Simon.

By the time Joel and I met in an academic arena, I was tired of pathology. I had worked with individuals who were labeled—depressive, anxious, borderline, schizophrenic, and addicted as well as individuals with obsessive-compulsive disorder and panic disorders. I was continually in an exchange and dialogue that surrounded their problems. I would ask them to provide me with a landscape of their past and the issues that brought them to therapy. The irony is that I was practicing what I had been trained to do; however, it was no longer exciting or productive either personally or professionally.
I remember the first conversation I had with Joel. He was working as the director of social work at a local hospice. I had brought my Social Casework class to the agency in order for the students to have an understanding of the types of career opportunities there were in social work. Joel started to talk about “solution focus.” The more I heard about this perspective, the more interested I became.

Due to this interest, I began to use Joel and Thorana Nelson’s book, Solution-Focused Brief Practice With Long-Term Clients in Mental Health Services: “I Am More Than My Label,” as the required text for my Theories of Social Casework course. There were multiple benefits in using this book. The primary benefit was that I was able to introduce students, on the undergraduate level, to the work of solution-focused brief therapy. However, with this book, I needed to incorporate supplemental material to show how solution-focused brief practice could be used in social casework settings. The need to supplement has changed now with the inception of this book by Blundo and Simon.

Blundo and Simon have successfully outlined how a solution-focused perspective can be a powerful tool for case managers. Their understanding and presentation are based upon practice scenarios that are real and applied; not driven, diluted, or distracted by a “theoretical perspective.” They clearly demonstrate the impact of “thinking and language” and the importance of building a collaborative relationship with clients. Their work challenges the traditional theory-driven interventions that focus on problems and arrive at a diagnosis. They encourage a “shift” to a coconstructive partnership that requires a practitioner to respect that clients are “experts of their own lives.”

In their work, Blundo and Simon provide the reader with an understanding of the history and origin of solution focus. In addition, they provide a clear stepwise discussion of techniques and strategies that can be employed, working with individuals and families in case management settings. They stress the importance of a conversation in which the client and worker build on strengths with an emphasis and understanding that the client has a personal responsibility for his or her journey to recovery.

As I have become more familiar with solution focus, I find it to be a freeing experience. The solution-focused paradigm has reignited my passion as a practitioner. I am no longer weighed down by the burden of pathology. I no longer look for patterns of pathology but rather for evidence of strength and the presence of hope.

I know that you also will find this work by Blundo and Simon to be refreshing, invigorating, and powerful. This book is a must-read if you are a seasoned practitioner or a graduate or undergraduate student in the field of social work, human services, or psychology. In utilizing the underlying foundations, strategies, and techniques found in this book, you will build value, depth, and dignity to your skill practice of case management.

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Preface

Recent literary theory suggests that the ability of the text to make sense in a coherent way depends less on the willed intentions of an originating author than on the creative ability of a reader.

—James Clifford

Growing requirements for funding, efficient use of resources, and increased caseloads for health and human service workers are resulting in greater demands for multiple services and integration of those services in order to engage people who are facing complex needs and challenges. These challenges range from domestic violence and child protective services to health, behavioral health, and rehabilitative services. Case management is becoming a necessary element of many health and behavioral health services, not traditionally seen as needing case management skills.

The consequences of this increasing need for professionals in our communities and our students to learn how to address complex challenges facing their clients or patients have resulted in our effort to write this solution-focused guide to case management. Hopefully we have created a useful guide to help you on your way to a new way of thinking about engaging clients/patients. In the first several chapters, we devote considerable time providing you with a new way of seeing the world that is very different from the usual problem, diagnosis, and intervention plan. The shift is in how you might engage your usual expert role with the client. We hope to shed light on this “way of thinking” so that the skills and processes can be used effectively.

As noted earlier, the common theme for students and professionals has been the challenge of examining and questioning their assumptions about clients and the need to “fix” the clients’ problems. The assumption that the professional needs to know about problems—their causes and their details—has been, and to a great extent continues to be, the traditional model that is

1 When referring to a professional relationship, the authors prefer to use the term “client” throughout this book rather than “patient.” The appellation “patient” is inherently medical. “Client” suggests a contractual and collaborative understanding between the client and professional.
followed. Even though it might appear secondary to the practice of solution-focused practice, we have learned from our students and the professionals we have trained in workshops that the true key to building solutions begins with challenging these fundamental “problem-focused” assumptions. We have also come to realize that shifting assumptions is not easy. We all have invested our time, money, and passions as we have adopted our respective theories and models. Changing perspectives requires a good deal of self-examination and the willingness to take a more skeptical view of our beliefs.

New research and theory development across various fields of study are presented as a way of creating a synergism of ideas that form the basis of the work. Although most solution-focused practitioners do not think about these synergistic ideas, we have found them helpful for doing solution-focused work. The curiosity about client strengths, social construction, positive psychology concepts, resiliency, and how one changes patterns of thinking and behavior are presented as a way of understanding this different approach to engage clients. How we think about ourselves and the client we are working with and the function of professional intervention determines the type of conversations we have with our clients.

Thinking as a solution builder (rather than a problem solver) requires a paradigm shift—a different way of thinking about those with whom we work (see Table P1). It assumes that even in the face of pain and struggle, people are doing the best they can at a given moment. To endure and survive difficult situations requires personal strengths and resources that are learned and utilized by the client.

<table>
<thead>
<tr>
<th>TABLE P1. Transitioning From Problem-Focused to Solution-Focused Concepts</th>
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</thead>
<tbody>
<tr>
<td><strong>PROBLEM-SOLVING APPROACH</strong></td>
</tr>
<tr>
<td>Take position as expert whose knowledge helps the client.</td>
</tr>
<tr>
<td>Obtain details of the problem.</td>
</tr>
<tr>
<td>Assess problem presented through the lens of presumptive theories of pathology.</td>
</tr>
<tr>
<td>Focus on what is not working, what is wrong, what deficit or pathology keeps clients “stuck” or feeling depressed about themselves or their lives.</td>
</tr>
<tr>
<td>Focus on changing pathological thoughts, emotions, and/or behaviors through insight, understanding of cognitive distortions, and other theoretical orientations.</td>
</tr>
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(continued)
Solution-focused practitioners not only take into account a client’s skills, abilities, and personal attributes such as driving a car, doing math, and being friendly or kind but also affirm the client’s abilities to survive difficult life situations. It is not just about treating people with respect but also about respecting their potential and not engaging them in conversations that serve to limit their potential. It means radically accepting them, their worldview, and their hopes for a better and more satisfying future.

Even if they have submerged their identity under the weight of a system that has labeled them as incompetent, defective, incapable, and incurable, solution-focused practice challenges these ideas by understanding that clients are not their diagnoses but are complex individuals who are capable of envisioning possibilities for a better life and have the personal and social resources to move beyond their current difficulties. Importantly, the belief is that each individual has within himself or herself the capability of self-determination and that professional expertise is based on building conversations that affirm individual competencies. As solution-focused practitioners, we think that our clients’ futures should not be limited by conversations that identify clients by their psychiatric or medical diagnoses or their disabilities.

Solution-focused work is focused on identifying and affirming the strengths of the person and amplifying the strengths and competencies that he or she has already demonstrated in his or her life. Whatever the situation or challenge, people do the best they can at a specific moment, given the resources they have at the time. Even given end-of-life situations, how the client lives these moments can be guided by the client. By definition, every problem has an exception. Exceptions are key to solutions to life’s challenges and struggles.

Each individual has personal resources and relationships that have and are acting as supports for the work to be done and the desired outcomes to be achieved. The solution-focused brief approach uses these strengths, abilities, and resources within a collaborative partnership to create with the client conversations that will enhance and make real those personal resources.

The work is done by looking toward the future and solutions rather than dissecting the past and problems, even in the face of death. By talking about strengths in terms of personal attributes and character and successes, however small, the solution-focused model turns away from reinforcing the negative symptoms and deficits and reinforces the strengths and potential for better outcomes. Within this book are the details of how the tools of solution-focused

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**TABLE P1. Transitioning From Problem-Focused to Solution-Focused Concepts (continued)**

<table>
<thead>
<tr>
<th>PROBLEM-SOLVING APPROACH</th>
<th>SOLUTION-FOCUSED APPROACH</th>
</tr>
</thead>
<tbody>
<tr>
<td>An expectation of resistance and assumption that resistance needs to be “worked through” if progress is to be made.</td>
<td>Expectation of cooperation between client and worker. An understanding that the onus is on the worker to accept the client’s reality.</td>
</tr>
<tr>
<td>Successful problem solving results in insight into the “deeper” meaning of the symptoms and the development of the problem solution.</td>
<td>The client has made a “good enough beginning” and can continue making progress on his or her own.</td>
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practice help to create useful conversations with clients that enhance and make real possibilities and problem exceptions.

We have made every effort to demonstrate how problems and solutions may not always be connected. The approach leads to seeing what is a possible goal and the steps to reach that goal. Solution-focused practice is well suited for case management’s many challenges and complexities.

The first three chapters are focused on the assumptions inherent in solution-focused brief practice and how these are a shift from traditional thinking about clients and their problems. The challenge of changing learned habits of practice is fundamental to doing solution-focused case management. This is followed by an overview of some of the basic constructs that will make up the solution-focused perspective, such as the relevance of a social constructionist perspective on language and meaning-making, and of positive psychology and the focus on hope, optimism, happiness, and human virtues. We hope to show how these perspectives are related and can be integrated to provide a synergistic foundation of ideas for solution-focused work.

Chapters 3 through 8 detail how solution-focused intervention tools effectively create conversations with clients that lead to positive outcomes. Growing requirements for accountability in terms of outcomes are also covered in Chapters 8 and 9. In addition, the topics of diversity and social justice and their relationships to solution-focused practice are explored. Finally, Chapter 10 summarizes solution-focused philosophy, assumptions, goals, and intervention tools.

In addition to the book content, a chapter-based set of PowerPoint presentations is available to qualified instructors. To request the supplemental PowerPoint materials, send an e-mail to: textbook@springerpub.com

An effort has been made to provide examples of processes to make the readings come to life and the content more meaningful to practitioners and students. Case management skills have been used for many years and in many ways for a wide breadth of issues and challenges. The major purpose of this book is to provide workers and students with a guide to how solution-focused practice may enhance their work with clients. The authors’ intent is that both seasoned practitioners and students will gain an appreciation of the underlying philosophy and practical tools of solution-focused practice.
Acknowledgments

First and foremost with grateful appreciation to Steve de Shazer, Insoo Kim Berg, and their team at Brief Family Therapy Center in Milwaukee, Wisconsin. They are the solution-focused pioneers who dared to challenge conventional thinking. We acknowledge the many solution-focused colleagues and friends we have come to know who inspire and make what we do exciting, relevant, and vital.

Joel wishes to acknowledge Bob who offered him the opportunity to collaborate on this book. Finally, he acknowledges the many clients and students who over the years have taught and challenged him and helped to hone his solution-focused skills.

Bob wants to express his gratitude for the inspiration and kindness extended to him by Insoo Kim Berg, Steve de Shazer, Peter DeJong, and Dennis Saleebey for their unwavering support and help in his growth as a person, teacher, and author. He also acknowledges with appreciation his coauthor, Joel, for having faith in this endeavor and his wonderful contributions to the collaboration.
Solution-Focused Case Management: Definitions and Meanings

Occupations could be said to have soul when they act as something more than just a technical enterprise at the service of the state, employers, and consumers.

—Friedson (2003, p. 172)

Case management has many forms and case managers is often the formal title of those working in specific settings that designate the work as case management. Importantly, case management is also practiced by professional service providers not specifically designated as case managers but who essentially perform those functions. These service providers work in many settings such as mental health, social services, child protective services, hospices, disability services, elderly services, and long-term and acute care services, among many others. Aspects of case management are becoming a part of the work of a wide range of health and social service providers. Practitioners in what is often considered a direct care service such as counseling, behavioral health, and medical treatments find it necessary to coordinate services with other providers and agencies. By definition, they are engaging in a case management process.

Case management can thus be considered an important aspect of any health and social service professional training. Nurse practitioners are often required by many settings to recognize the need to develop case management skills (McAllister, 2007). The baccalaureate social work practitioner is very likely to be doing some form of case management in whatever setting he or she is employed. Counselors, master’s-level social workers, and other service providers are often required to coordinate services, act as ombudspersons for clients, and negotiate on behalf of clients for interagency services. The ability to perform case management functions is an important skill independent of the job title.

Definitions of case management are, as expected, written in broad strokes, attempting to suggest a larger range of responsibilities in a concise statement. Most often, they are focused on those whose jobs are designated as case management. The following are variations on how case management is defined. Notice that the partial description of case management provided by the
National Association of Social Work (NASW, 2013) implies that the case manager should follow the traditional concept of problem-focused approaches. The basic ideas are a focus on problems and that the worker is the expert and central in the process and effort to be made:

Social work case managers face both opportunities and challenges. With its strengths-based, person-in-environment perspective, the social work profession is well trained to develop and improve support systems (including service delivery systems, resources, opportunities, and naturally occurring social supports) that advance the well-being of individuals and families.

Furthermore, social workers have long recognized that the therapeutic relationship between the practitioner and the client plays an integral role in case management. (italics added; NASW, 2013, p. 8)

Yet another generic description of case management by the Case Managers Society of America provides a more complex description while maintaining the central role and expertise of the case manager. The scope of case management is described as the process that

serves as a means for achieving client wellness and autonomy through advocacy, communication, education, identification of service resources and service facilitation. The case manager helps identify appropriate providers and facilities throughout the continuum of services, while ensuring that available resources are being used in a timely and cost-effective manner in order to obtain optimum value for both the client and the reimbursement source. Case management services are best offered in a climate that allows direct communication between the case manager, the client, and appropriate service personnel, in order to optimize the outcome for all concerned. (italics added; Case Management Society of America, 2013)

Traditionally, case management was described as starting with assessment by the worker so that the worker could make the necessary connection with services he or she found necessary for the client (Laurie, 1978). With time, changes were made in an attempt to shift from “management” to “coordination” of services in order to eliminate the idea of control, treatment, or direction in favor of the new idea of “empowerment.” Case managers themselves complain that we demean people when we refer to them as “cases.”

Even though the term case management is the most widely used term to date, the meaning has evolved away from the traditional sense of “managing” the client. Summers’s textbook (2006), The Fundamentals of Case Management Practice: Skills for the Human Services describes the work as having the client “learn to be independent, adopting useful and appropriate work habits, practicing good interpersonal skills and behaving appropriately” (p. 48). This demonstrates the client being seen through the lens of the problem-focused model of practice. The client is assumed to be incompetent rather than having strengths and potential. Woodside and McClam (1998) describe case management work in this manner:
The goal of case management is to teach those who need assistance to manage their own lives but to support them when expertise is needed or a crisis occurs. These professionals gather information, make assessments, and monitor services. . . . They also provide direct services, describing their responsibilities broadly as doing whatever is necessary to help the client. (p. 5)

Case management is a prominent element in health settings. Both nursing and social work play significant roles in bringing together and coordinating services:

the process of organizing and coordinating resources and services in response to individual healthcare needs along the illness and care continuum and in multiple settings. There are many models of case management given the client, context, or setting. Case management is directed toward a targeted or selected client/family population such as transplant, head-injured, or frail elderly clients. The goals are to center services around the patient, to foster patient self-managed care, and maximize efficient and cost-effective use of health resources. The focuses are cost-saving and continuity and quality of patient care. The Nurse Case Manager utilizes clinical pathways in assessment and monitoring of clients and healthcare delivery. (Nurse.com, n.d.)

Importantly, this definition is clarified by calling attention to not only the characteristics of the practice but to its “drawbacks.” These include “honoring client choices, minimizing time constraints, maintaining a holistic focus, linking care-team members, and impacting quality and cost” (Nurse.com, n.d.).

Given the restraints of cost-effectiveness, case management within a health care setting will be a challenge for those wanting to work with clients in a collaborative and client-directed manner. It is our belief that by utilizing a solution-focused practice, it is much more likely to engender a mutual working relationship that is client directed and focused on the strengths of the client and their resources. The following definition of solution-focused case management demonstrates the possibilities for client-directed and holistic approaches to working with clients.

The Northwest Brief Therapy Training Center in Olympia, Washington, presents a solution-focused description. It is also an attempt to shift the perspective from the traditional assessment and expertise of the worker to viewing the client as the expert with strengths and possibilities:

Solution-focused management is a powerful, practical, way to achieve positive change with people, teams and organizations. It identifies what is already working and amplifies it to make useful changes. It focuses on what is possible rather than on causes of problems and gets managers to stop doing what isn’t working and do something different. Several principles characterize the approach, including simplicity, cooperation, and an emphasis on strengths, resources and abilities of the organization and its members. The focus is on interaction between individuals and teams and holds individuals accountable. Possibilities are
explored in the past, present and the future. *Exceptions and even small changes are used to achieve desired goals.* Every case is seen as different and expertise for achieving solutions is located with the person or team that wants to change or improve. (italics added; Northwest Brief Therapy Training Center, 2014)

Notice the shift in focus from the traditional problem-based caseworker being the expert problem solver and change agent to the solution-focused caseworker viewed as working collaboratively within the world of clients and the systems surrounding them. *The client system and resources are the collaborators and experts of their own lives.* This represents the fundamental shift from a problem focus and the role of case manager as expert to one of a solution-focused perspective in which the client and system are experts (see Figure 1.1).

Our goal is to present the material that we have used in teaching the basics of solution-focused practice and case management to undergraduate students, graduate students, and professionals who attended training workshops. What has emerged is the recognition that a common theme for students and professionals learning solution-focused practice has been the challenge of examining and questioning their assumptions about clients and the need to “fix” the clients’ problems.

The assumption that the professional needs to know about problems—their causes and their details—has been, and to a great extent continues to be the basis of the traditional model that is followed. Even though it might appear secondary to solution-focused practice, we have learned from our students and the professionals we have trained in our workshops that the true key to building solutions begins with challenging these fundamental “problem-focused” causal assumptions of the position of expert and manager of the problems and service systems.

![Figure 1.1: A Comparison Between Problem-Focused and Solution-Focused Practice.](image-url)
We have also come to realize that shifting assumptions is not easy. We all have invested our time, money, and energy as we have adopted our respective theories and models. Changing perspectives requires a good deal of self-examination and the willingness to question our assumptions about ourselves, our clients, our responsibilities, and our clients’ responsibilities in an engagement.

The word solution in everyday language usually refers to what one might do: actions one would take to change an undesired situation. Solution-focused practice shifts the concept of solution to mean what is wanted or desired as explicitly stated by the client. The focus is on taking steps to a better future. Solution-focused practice invites fuller appreciation of human agency and potential. . . . focuses more on the strengths and resources that [people] bring to the [collaborative work] than on the weaknesses or limitations . . . more emphasis is put on where people want to go than on where they have been. While not ignoring the painful and seriousness of some situations, the shift has been away from conventional psychiatric pathologizing and toward a more optimistic [and hopeful] view of people as unique and resourceful creators of their own reality (for better or for worse). (Hoyt, 1994, p. 1)

Theoretically, problems require that the practitioner be the expert and have a theory or model to detect the underlying cause of the problem. It is this past causation that must be explored, labeled, and treated. The “problem” is seen from a different perspective in solution-focused work. The “client’s problem” is discussed to the extent that the client feels not only understood but also appreciated and supported in his or her capacity to have made it so far. This is done directly by inquiring about how the individual has coped with challenges, exceptions to the problem, and personal and social resources. Notice this simple shift in language from thinking in terms of problems to thinking of solutions. The problem is most often appreciated and respected by the solution-focused worker by listening and acknowledging how difficult it is or has been and then asking, “How did you keep going?”

The solution-focused perspective shifts the manner by which case managers relate to those with whom they are engaged. The primary focus is with the specific client and building a real relationship that “engenders notions of trust, safety, confidence and empathy, sufficient to enable both client and helper achieve their purpose together” (Winbolt, 2010). This shift is intended to create a meaningful, honest relationship that enables the worker and the client to build mutual rapport or a feeling of a mutual understanding of each other. Feeling trust and rapport must be built quickly given the immediacy of needs to be met. Solution-focused practice provides for an opportunity for clients to experience being listened to and heard by the worker. Battino (2006, p. 34) described this as “what is it like being in their world. There needs to be a sense of collaboration, that is, we are in this together, and together we can develop ways of helping you.”

One of the misconceptions is that by focusing on solutions, we are therefore ignoring the problem. De Shazer (1991) writes: ‘The concept ‘problem’
always presupposes the concept of ‘solution.’ In fact, the concept of solution is a precondition essential for the development of a concept of problem” (p. 122). Conversations about solutions imply problems—the two are intertwined and cannot be separated. When videos of solution-focused conversations are reviewed, very little time is spent on problem talk even though when clients are asked how solution-focused conversations were helpful, they often respond that they had a chance to talk about the problem (Simon & Nelson, 2007). When you or your client is asked about what the solution or resolution of an issue would look like in concrete behavioral terms, the problem becomes evident. If you describe a better marriage as the outcome of the work together, then the “problem” is with your marriage as you see it in terms of specific details. For example, if I state that I want to be able to spend more time with my spouse, I have given a specific detail to work toward and specified a particular problem to be addressed. By following detailed descriptions of my goals or desired outcomes, as the client, I have revealed possibilities for how I might reach that goal. I am able to identify times when just a part of that goal has been achieved and how it was created.

Solution building does not focus on problems but focuses on client goals, hoped-for futures, and exceptions to the existence or intensity of the “problem.” The expertise of the worker is in engaging in a conversation with the client in a collaboration of unveiling of potentials, competencies, resources, past successes, and problem exceptions, as well as in being curious about how clients keep going in difficult situations.

SHIFTING INTO NEW IDEAS

All of us as helpers, when faced with an innovation, have to engage in a process of meaning-making, of weighing up this new idea against our existing ones, in the process of deciding whether it is something we are going to make an effort to learn, try out, and then use in our work. (Walsh, 2010, p. 2)

For the experienced practitioner, change is often more difficult as each practitioner has integrated a particular perspective that seemingly becomes the correct way of engaging situations in case management or in counseling. It is also familiar and habitual, which provides a sense of “knowing” that is comforting when dealing with complex challenges. “It has done well by me in the present and the past, so why change now” is often the comment made when new ideas are introduced to seasoned practitioners. Meanwhile, the novice practitioner is obviously more likely to entertain the approach, having no previous embedded practice experience. Margaret McAllister (2007, p. 9) addresses this situation by defining solution-focused practice for nursing as a philosophy:

Solution-Focused Nursing . . . assumes that nursing work is and can be, more than problem focused. It involves working with and for clients,
so that health and well-being, meaning and life adaptation are promoted. This requires that students of nursing learn to move beyond a problem orientation.

Solution-focused case management requires an important shift in thinking, which will be evident throughout the chapters to follow. It is important to initiate this shift here with a few comments about problem-based case management. Being a client and having a designated “problem” changes the work by identifying the person as the problem. No longer is the individual a unique and complex person with many assets, strengths, abilities, and possibilities, but now the “problem” defines who they are. The “problem” now justifies the need for the case manager to determine the exact cause, which then requires a certain type of intervention to address the problem. Charles Rapp (1998) describes this phenomena nicely:

If alcoholism is defined as the disease of excessive alcohol consumption, then the therapeutic approach must be centered on abstinence. Getting an alcoholic [note the new term for the person] to stop drinking is the first step in recovery. In this way, alcohol is both the center of the problem and the treatment. Even when someone is successfully sober for long periods of time, alcohol remains a central concern of his or her life. The image of the bottle is as prevalent in sobriety as in drunkenness.

This is referred to as the damage model by Wolin and Wolin (1997). This thinking results in individualizing the problem. The persons themselves are the cause and in need of changing. Charles Rapp (1998) points out that even if severe poverty and turmoil in a person’s life are obviously impactful on how a person might live their lives, our focus is almost exclusively focused on the individual’s apparent deficits and problematic behaviors. The focus of training and practice is with the individual and not the social context. Even though most helping professions talk about the social context, actual practice is directed at the deficits and problematic behaviors of the individual. In this way, the individual is seen as the cause of his or her problem and needs to “own up to it.”

The manner by which we conceptualize clients or patients has roots in our own neurological processes. Our brain is programmed to protect us by looking for potential danger. The limbic system, in particular the amygdala, looks for danger and operates in a nonconscious manner. This allows for very rapid awareness of danger or negative possibilities. If we were to have to think about danger, we would often be too late to deal with it. We are thus “programmed” to be on the lookout for danger or problems in any form. Positive experiences are fleeting. That is, we do not shift easily to that position. Negativity, in any form, is the default setting. It is more than likely that we will focus on what is wrong than what is possible. With training that focuses the case manager’s attention on the damaged person, it is only reasonable that this would seem the most appropriate and correct stance to take.
As solution-focused practitioners, we learn to manage the built-in fixation on problems or threats. This is not as easy as it might seem. Practice and attention need to be ongoing to shift our automatic concern for problems and fixing them. As solution-focused case management practitioners, we need to develop a respectful curiosity about the unique abilities people have of being self-correcting. This means a shift from the lens focused upon pathology to that of how people within their life contexts keep going in spite of whatever traumas or difficulties they face. It is not primarily the intervention skills of the worker but the basic innate wisdom of each individual and the capacity for solution building that drive effective solution-focused brief practice. Ultimately, clients decide what actions are possible and useful so they can experience more satisfying and fulfilling lives.

This respectful curiosity from a place of “not-knowing” attention is a shift from the typical categorization of people and problems to being concerned with strengths and possibilities. When coming from a solution-focused perspective, it is held that “genuine framing of a person’s strengths can do more good than a well-timed, genuine framing of a person’s problems and weaknesses” (Sharry, Madden, & Darmody, 2012, p. 8). Linley and Joseph (2004) maintain that the struggle to shift from a pathological or problem-focused perspective to one of strengths and implicit hopefulness is fundamentally a question of values. Each of us comes to translate and make meaning of the world outside ourselves through a coconstructed lens that is rooted in social discourse throughout our lives. Professional training further adds its own set of values and assumptions about the client, the case manager, and the purpose of the implicit or explicit contract.

Problem solving–based theories assume that the focus must be on the negative, and the concomitant language that is typically used not only dictates our interventions but also explains why things do not work as the theories suggest they should—typically, this means blaming the client. Problem-solving theories use words such as “resistant,” “not ready,” “in denial,” acting out,” “noncompliant,” or “transference” to explain the lack of progress. The following exercise helps us explore the implications of these plausibility structures further.

Exercise: How Our Assumptions Determine How We View the Client

CASE #1

You have just been assigned the case of a person who has been released from a psychiatric ward. The person stated to the intake worker that he was “feeling somewhat anxious about the future, including a job and other issues in life.” Given this small amount of information, even though you do not think it is not enough information, pay attention to what your first thoughts were about this person. If you could only ask three questions, what might they be? How quickly did the questions come to mind? Do the three questions have a theme or focus? Write this down or remember the details of how you reacted to this simple request for help. Now, let us try another situation.
CASE #2

Let us assume that you have been assigned the case of a person who has just graduated from college. This person told the intake worker that he or she was “feeling somewhat anxious about the future, including a job and other issues in life.” Given this small amount of information, what was the very first thought or ideas that came to mind? What was your initial impression of this person? What questions would you like to ask? As before, if you could ask three questions, what would they be? Write this down or remember the details of how you reacted to this simple request for help.

Even though there is little information, there still is a tendency to quickly begin making assumptions about a client. As we have been describing, we humans are somehow conditioned to focus on negative events—in this case, the words “released from a psychiatric hospital” certainly stand out. It would be natural to make a quick judgment about this potential client versus the words “just graduated from college.”

Even when provided with greater detail, there is still a tendency to view a client negatively. This makes sense, given that the ostensible purpose for psychological treatment is to diagnose and treat mental illness and therefore the focus must be on uncovering and diagnosing problems. In one study (diNardo, 1975), 60 psychology students were divided into different groups. Each group was shown an interview with a “patient.” The interviews were identical except that in one case, the patient was described as being of middle socioeconomic class. In the other group, the client was described as lower socioeconomic status. In each group, the participants were asked to suggest a diagnosis. The “patient” described as of lower economic status was consistently given a more chronic diagnosis.

This ability to make quick judgments is actually very useful when you are in dangerous circumstances, as many of our ancestors were when hunting and encountering animals and other unknown groups of hunters. In this case, the quicker one could judge the situation, the greater the chance for survival. No doubt, there are obviously groups of people still living in such situations around the world, but most people face different life stressors such as driving along highways, meeting job expectations, taking tests, paying bills, and meeting with supervisors, friends, strangers, teachers, and clients. In the present day, most people are not part of a band of hunters living in caves in remote regions armed with only their spears and wits.

We are put on alert by many negative circumstances we see in our own lives, the lives of friends, and even the news from around the world. We are not only put on alert by paying attention to the negative event but we also quickly decide how to respond.

The theories and models that guide case managers dictate how they will react and respond to clients and, in turn, how clients respond to case managers. Case management is not a matter of organizing a set of abstract resources to help another person or family. Case management is constructed around building collaborative relationships not only with clients but also with many different players in an effort to assist clients.
The assumptions that are made drive future actions. The information given about the client including his or her diagnosis naturally dictates how we will think about the client and what conversation we will have with that client. What we assume about a client will determine how we act toward that client and how we would want the client to fit our assumptions. When the client does not fit the assumptions, the client is perceived as resistant. The information is often incomplete and inaccurate, yet it is the very information upon which we act.

Suppose that the information in Case #1 was changed and the client was actually a young woman of 22 by the name of Chelsea. How might that alter any assumptions you had about the client? What if we added that she was hospitalized briefly for depression because her parents had been killed in a terrible accident? What happens now to your assumptions about this person named Chelsea? How do you think those new assumptions would change the conversation you might have with Chelsea? What kind of conversation might you have with her given this new information?

Obviously, the difference is not only the quantity of information, but also the nature of the information. Think about what changes might have taken place as different information became available. What about the quick assumptions we all tend to make with just a bit of information? What types of questions did these very first assumptions lead you to consider asking?

In the examples we presented, do you recognize how quick and easy it was to build a picture of this client? Who is “the real” Chelsea independent of how we see her through the lens of incomplete and inaccurate information? Our own life experiences affect how we think, feel, and behave in reference to others and the world.

Research on cognition and social cognition confirms that these ways of thinking, categorizing, and paying selective attention are how we are hard-wired to organize, store, and access information. The material presented in the preceding exercise came from an experiment conducted by Pierce (1987). He researched how negative information biases the helper. Pierce concluded that the descriptor “psychiatric ward” produced significantly more pathology-focused conclusions than the phrase “college graduate.” The problem-focused conclusions were made without any additional descriptive information. Also, the young woman who had been in a psychiatric ward was more likely to be described in negative ways.

What we learn from Pierce’s research is that the conclusions made about clients are less influenced by objective data and more by the evaluator’s own biases. What makes these conclusions even more seductive is how they become couched in professional jargon. Through the use of professional language, we become habituated to thinking from a very specific frame and tend to see the world through this learned and reinforced frame or lens. In addition, we are influenced, often subtly, by a person’s physical appearance and even a person’s name. The more we become aware of our potential biases, the more likely we will be able to recognize them and keep them from influencing our listening to and hearing of the client’s life narrative. Solution-focused practice requires the ability to attune to the client’s world without interference from our personal and theoretical lenses.
CONCLUSION

The material we have covered provides the foundational assumptions about solution-focused work. It is essential to using the techniques and skills that we cover in the subsequent chapters. Without this fundamental perspective, the skills become ineffective and problematic. The beliefs and principles you bring to this work are as important to understand as the basic techniques and skills. These are required to gain the ability to join with clients and systems from a not-knowing position. The benefits of listening without interpretation:

Unfortunately, much of what has been written about and considered empathic has focused almost exclusively on the therapist’s identifying and connecting with the client’s negative feelings and personal experiences (e.g., clients’ pain or suffering, their despair or feelings of hopelessness, their present difficulties and the history of the complaint). However, since client strengths and resources contribute greatly to psychotherapy outcome, we would do well to adopt a broader view of empathy, a view that encompasses the light as well as the dark, the hope as well as the despair, the possibility as well as the pain. (Miller, Duncan, & Hubble, 1997, p. 12)