Chapter 8
"E" Is for Empowering

8.1 Getting to Empowerment

Empowerment of patients is a crucial element of an approach to primary care that improves outcomes for patients and lowers cost for payers [1, 2]. Patients who experience themselves as empowered, as partners in their relationships with their doctors, are generally the same patients who feel empowered in relation to their own health [3]. They are more likely to take the actions that maintain or improve their health. These are patients, on average, whose healthcare will cost significantly less in the long run than those who do not feel able to influence their healthcare or impact their health.

"Empowered" patients should not be confused with patients that health professionals sometimes call "enfranchised" because they seem inappropriately demanding of their healthcare teams. Empowered patients are able to participate in a partnership, to share in planning their care, and able to act autonomously to maintain their health. Enfranchised patients generally are not experiencing a partnership with health professionals; rather they tend to see health professionals as controlling their access to tests or treatments that they think they need. When a genuine partnership can be developed with these patients, one that involves an agreement on the goals and the methods for reaching the goals and that honors the expertise of the professionals as well as the desires of the patients, both patients and clinicians experience themselves as more empowered.

In Chap. 5, we looked at a group of patients who have particular trouble forming partnerships with their doctors and healthcare teams. These are patients who are described in different ways in different literatures. They are a subgroup of "complex" patients, those who are high utilizers of healthcare resources, who have multiple chronic illnesses, often including behavioral health disorders. Many are people of low socioeconomic status, whose low levels of educational attainment make participating in the complexities of healthcare difficult for them and for their clinicians. Many cope with language barriers and/or with societal discrimination. Many have

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histories that include experiences of trauma that have affected their coping abilities and their health. Studying these extremely high-cost individuals, Mautner et al. [4] found that besides their histories of trauma, a great many had histories of what they experienced as inadequate, dismissive, or demeaning interactions with the health-care system. Doctors commonly are less likely to take a patient-centered approach to these patients, believing instead that they need a more directive approach because of their challenges in understanding and in adherence [5, 6]. These are people for whom an offer of empowerment, in its more political sense, i.e., an invitation to share a partnership with health professionals in planning their care, is not likely to have the desired effect. Building trust and the experience of self-efficacy has to precede the invitation to partnership.

In working with multiply-disadvantaged patients, the meaning of “empowerment” that is most immediately relevant is the meaning used by practitioners of trauma-informed care (TIC) [7]. In the TIC approach, “empowerment” means that wherever possible, the patient’s strengths and successes are used as a basis for building toward their better health and functioning. In addition, hierarchical relationships between health professionals and the patient are likely to be a reminder to the patient of unsafe times in the past, when they did not have power to avert one or many traumatic experiences. TIC becomes an organizational commitment that flattens hierarchy among team members as well as between team members and patients [8].

To a person in any of the helping professions who has been trained to ease suffering by solving or alleviating problems, either physical, emotional, or social, the idea of starting by focusing on what the patient does well, or where they have been successful in the past, can appear to be inefficient at minimum or even misguided. In simple situations, this might be true. Studying the functioning and health of the arm that isn’t broken rather than treating the arm that is broken is certainly not the best use of the time of the health professional or the patient. However, in situations in which the patient’s understanding or definition of their own situation, and the future actions they take based on that understanding, will make a difference in their physical, emotional, or social outcome, focusing them on what has worked in the past and how that can relate to the future can be the most efficient use of time and energy.

The precepts of trauma-informed care (TIC) provide conceptual guidance for implementing the “the patient as the source of control” of their healthcare, but in general they do not specify in detail what actions can be taken or what words can be used to accomplish the purpose outlined. There is a proven methodology for enacting this sort of empowerment. In Chap. 11, we describe one version of this methodology, the version targeted at developing collaboration within groups of co-workers and teams in organizations, when we talk about “appreciative inquiry” for building the healthcare team [9]. We highlight how working from staff members’ strengths helps build the empowerment for them to take on more complex and more autonomous roles.

In a clinical situation the same general methodology is called “solution-focused interviewing” (SFI) [10]. SFI consists of questions designed to highlight strengths,

successes, and solutions in a way that is oriented toward helping a person make further progress. The method is a distillation of some of the techniques developed in the 1960s and is called systems-oriented (or "systemic") brief therapy [11]. SFI resulted from research that attempted to rigorously correlate behaviors by a clinician in systemic brief therapy sessions with a patient's subsequent report of improvement [12]. The researchers, studying videotapes of visits, sought to isolate the behaviors by therapists that correlated most strongly with improvement and achievement of patient goals. They used a method called "sequential analysis" [13] for reliably designating specific categories of therapist behaviors. This naming of categories of behaviors allowed for mathematical correlations of therapist actions with later behaviors of patients to be done. The findings were striking. They determined that the more the therapist talked about problems, analyzed problems, looked at sequences in which the problems occurred, and talked about causes of problems, the less likely positive change was to be reported by patients. The more the therapist *elicited* descriptions of change or of exceptions in the problem patterns, or *amplified* the patient's description of change, or *initiated* descriptions of change by reframing a problem or by suggesting new behavior, the more the patient was likely to report a positive outcome and the achievement of therapeutic goals [12]. Therapists interviewed for solutions by asking: What would the solution look like? How would you recognize the beginnings of a solution as it developed? What previous examples of similar solutions had occurred? What exceptions to the problem patterns had occurred? What had the patient said or done that seemed to help toward those solutions?

The insights of the study of solutions in brief therapy and the focused approach to interviewing that it engendered are useful and effective outside of a psychotherapy setting. While "solution-focused therapy" describes an approach to creating change in a brief psychotherapy, "solution-focused interviewing" describes a general way of approaching communication in a helping relationship that tends to lead to improvement by focusing on strengths, on what works, and on a patient's history of exceptions to problem patterns.

Solution-focused questions are not contrived to lead patients to certain conclusions or realizations; they are ways one person tries to understand the strengths or determination or creativity or values of another. In the process, the other person is likely to become more aware of their own strengths, determination, creativity, or values. As the patient experiences themselves as more likely to achieve positive results or solutions, their hope for success and their willingness to try are likely to be strengthened.

The findings of the Gingerich et al. study [12] correspond with more mainstream science of brain function and memory. Recent neuroscience [14] helps to explain a phenomenon that I have observed in my clinical experience of using SFI for over 30 years. I found that early in a visit if a patient was asked about times when they did better than in their current problem situation, times when they were successful to some degree in the problem area, the answer was often, "Never." They could not think of a single time in which there was an exception to the current pattern of problems or pains. After a conversation that featured some of the solution-

focused questions discussed below, their report of their history often had changed. They could remember actions that worked, how they had helped to create instances that were an improvement on their current problem situations. When people experienced themselves as currently unable to find a solution, they often experienced their history as characterized by a continuous sequence of failures. When they experienced themselves as having been able in some instances to effect better outcomes, they remembered a pattern of events that supported that picture. This change in their experience of one part of their history tended to correspond with a small change in their current sense of themselves which connected to a small change in their understanding of the possibilities for the future. "If I made it work in the past, possibly I can make it work in the future." A small change in a person's expectations of the possibilities for the future can make an important difference in their commitment to action toward improving their situation, such as working for better health.

Hasselmo [14] reminds us of the difference between "semantic memory," the memory of facts and knowledge of the world; "procedural memory," the memory of how to do something; and "episodic memory," the memory of an episode of experience in space and time. He points out that one memory can cue access to other memories that have similar elements, based on the salient details of the first memory as determined at the time of access. He uses the concept of "reciprocal richness" to describe the way in which, when one memory of an episode cues access to a similar memory, the richness of a detail in the first memory can mean that the second memory is accessed with a richness of detail borrowed from other elements in memory, enhancing the newly recalled memory with a vividness it may not have had at the time it was created. Our current pur- pose or emotional state helps determine what memories are accessed, and the details of those memories that we experience as important are enhanced in rich- ness. Research on memory and the brain supports the observation about SFI above [14, 15]. Garry and Polaschek [16] express it clearly in their summary for a popular audience:

> The "autobiographical (episodic) memories" that tell the story of our lives are always undergoing revision precisely because our sense of self is too. We are continually extracting new information from old experiences and filling in gaps in ways the serve some current demand. Consciously or not, we use imagination to reinvent our past, and with it, our present and our future. (p. 66)

Put another way, our personal history is the story we remember and unconsciously create to explain our current experience of ourselves and our situation. When our current experience of ourselves and our situation changes, a somewhat different history is likely to become available in memory. Helping people experience themselves as able to create solutions makes different episodes in their lives come to mind, episodes that logically lead to their being able to continue in their more adaptive path. In the process, the interviewer's experience of the patient, about the strengths and potential of the patient, changes as well. New hope and energy are infectious. New hope and energy, the experience of being effective, correlate with lower burnout for health professionals.

Coping is a daily challenge for multiply-disadvantaged patients. For many people, asking about what works or about their strengths will not be an approach that engages them. Feelings of frustration or vulnerability tend to be primary when they think about their experience. Accounts of successes or of taking steps to make their lives better may be hard to elicit. Solution-focused interviewing can also include coping questions that ask not about patients' successes but about how they have kept their currents situations from being worse. Sharing information that the patient experiences as characterizing their coping and their determination can begin to build engagement between the patient and the team. As people feel more confident in the importance of their knowledge about their lives and their functioning, and as they are surer of the respect with which they are regarded by their care team, they are likely to become more open in sharing their thoughts and to ask for the specific information that will help them.

Using solution-focused interviewing may seem to team members to add too much time to the little time they have for their interaction with the patient on a given day. In the cases of many patients, that could be true, and good care through partner- ship can be achieved without the addition of solution talk for those patients. In the case of multiply-disadvantaged patients, however, the likelihood of their taking up a lot of time is very high, perhaps not in one visit, but in the many visits required by their care in the health system. Any extra time that is given to helping them engage more effectively in their care and to experience themselves as more empowered in relation to their care team will be likely to save time later. Teams that become pro- ficient at solution talk will find that they use it throughout their day. Over time, it is likely to become not an extra approach added on but a way of working with everyone.

8.2 Solution-Focused Questions[1]

Questions that tend to help discover solutions can be grouped into several categories. The following are common, but there can be many more [17]: pre-visit change, coping questions, questions about what you would keep, exception questions, scaling questions, and questions about what the solution would look like. Each of these questions can be the beginning of a period of "solution talk" [18]. Solution talk, as opposed the "problem talk" that is usual in healthcare settings, tends to focus on the future rather than the past, to notice resources rather than problems or failures, to highlight the agency of the patient rather than their being a victim, and to build partnership between the interviewer and the patient. Noticing when the conversation is in solution talk can help the interviewer in assessing the interaction. While

[1] The descriptions of SFI and the questions offered here were influenced by a number of sources, both by the pioneers (de Shazer, Berg, Furman) and by my students, particularly the family medicine residents that I taught over the years. I do not claim, however, that any of them would endorse my formulation of the method.

problem talk is inevitable, the more the interaction can be conducted in solution talk, the more the patient is likely to experience their past, their current situation, and their future as empowering and energizing toward partnership on their health-care team.

Pre-visit Change Questions help a patient notice any slight improvement that has occurred since they made the decision to come for a visit about a particular problem or symptom. These questions are particularly applicable in the first visit about the problem or symptom. The question can be phrased, "Sometimes when people make a decision to get help in addressing a problem or symptom, they notice that there is a slight easing of its intensity for a time before the visit occurs. Is that something that you noticed in your situation?" If the patient says everything stayed the same or got worse, the questioner can move on to another topic. If the patient says that things did get slightly better for a time, the next questions can be phrased to have them describe very briefly how they experienced things during that slightly easier time and if they did anything that seemed to correspond with that slight improve- ment. Whenever there is a report of things easing or getting slightly better, there is an opportunity to ask if the patient did anything that might have contributed to the improvement, however temporary. If they can identify something they did, the interviewer has helped to identify in the patient's mind an instance in which the patient had some effect on their situation or created the beginnings of a solution. If the patient can't identify anything that they did, the topic of their potentially being someone who makes a difference in their own problems or symptoms still has been broached. This introduces the topic of self-efficacy which will be useful to the interviewer and the patient in the future.

Note the incremental language: "slight improvement," "ease up a bit," "for a brief time." When people have struggled with physical, emotional, and/or social problems for a significant period of time, the changes and improvements that they can notice are likely to be small. Helping them begin to notice and to look for these small changes can make it easier for them to notice future improvements.

Coping Questions are helpful in the many situations in which patients cannot remember instances when things had been better or easier. At such a point in the conversation, the next question can be about how they have managed cope as well as they have. Another way to ask about coping is to enquire about how they have kept their situation from getting worse than it is. The question might be worded something like the following: "You have been facing this terrible difficulty for a long time. How have you managed to keep it from affecting your life (pick whatever fits — your work, your relationships, your family, your sobriety, your coping with your symptoms, etc.) even more than it has?" When the person can't think of anything that counts as coping, sometimes a question that can get a brief time of solution talk going is to say: "You know I work with a number of people with similar levels of struggles to the ones you face. I have to tell you that many of them, if they felt like you do today, would not have made it in for this visit. They would not have made it out of bed, much less have kept their appointment here. What was it that

helped you make it to this visit in the face of the difficulties (or symptoms or pain) you have?"

Often the answer to the question about keeping the appointment is something that allows a second question that highlights the personality or values of the patient. If they say they made it to the appoint because they try to keep their commitments, the interviewer can ask if that determination to live up to their commitments is typical of them. If they say that they had to try to get some relief, the interviewer can observe that they seem to be determined to find some solution or improvement. Is that determination typical of their approach to troubles generally?

The word "determined" in the follow-up questions begins to create a characterization of the patient as showing self-efficacy, even in a very difficult situation in which they have not seen any relief to date.

What Would You Keep? When the patient's situation seems overwhelming, to the patient and to the interviewer, the "what would you keep?" question can be a way of changing into a conversation about what is working or is valuable in their lives. This is sometimes used as a part of creating an agenda for a visit or meeting. The interviewer has gone over the problem list and has heard of new problems that the patient brought on that day. They are preparing to focus on what can be addressed in the meeting time that is available. The question can be phrased in the following way: "You are facing so many difficulties, no one could blame you for wishing there was a way to get a life where your list of troubles was much shorter. Suppose you were able to make a lot of things change for yourself, what part of your current life, your current activities, your current relationships would you want to keep in any future time?"

Whatever elements the patient identifies are likely to be things that they identify as valued or as working. Those elements can then be the focus for a brief discussion in solution talk. How has the patient kept those elements going amid all their difficulties? How have those elements of their life helped or sustained them when they faced other challenges? Are there things that they learned in maintaining or growing those elements in their lives that they will use today as a help as they work with the current team member to address the challenges to be addressed in the current visit? Setting an agenda for work is more likely to be experienced as a partnership and as likely to be productive by the patient if they start the visit in solution talk.

If the conversation about what they would keep has already occurred, the visit can be started by asking about the life elements identified in the what-would-you-keep conversation earlier. The health professional might say, "I still remember when we talked before about how you would want to keep your relationship with your daughter as important, no matter how your life changed in other ways. Have you been able to do anything to maintain that relationship or to enjoy time with her since we talked?" To be able to keep this continuity of solution talk, it has to be documented. The health professional should include enough information in a note about what the patient would keep to remind both of them of the conversation next time. The note can also be helpful to other team members who know the significance of

the question. Another team member who was meeting with the patient might say, "I can see in Dr. Peterson's note that no matter what we do, we want to be sure to support your relationship with your daughter. That is very helpful. So I can understand what works for you, maybe you can say a little about how you have been able to keep that relationship alive and valuable in the past."

Exception Questions are used to study times when things work better, even when the vast majority of the conversation is about problem times. Exception questions look for times when the problem did not happen, or happened with less intensity, or happened as usual but had a slightly less powerful impact on the patient or their functioning. To start a conversation about exceptions in a medical setting can usually be done by asking if the problem or symptom is worse on some days. Does the patient have bad days and good (or not as bad) days? In the majority of cases, the answer is yes. While the patient may expect the next question to be about the worse days, the interviewer focuses on the better days. What makes a better day? What happens or doesn't happen that lets the patient know it is going to be a better day? Is there any point on the day before the better day at which the patient could predict that the next day would be a better day? Is there anything that the patient does or that someone else does that seems to contribute to increasing the chances of a better day? For any of these questions, if the answer indicates some pattern to the excep- tion, it can be investigated for another question or two.

Another way to identify an exception is to count instances of the problem. In a medical setting, it is common to ask patients to keep a pain diary, or a record of the intensity of their anxiety, or a record of some health behavior that they are trying to improve. When reviewing the diary at a subsequent visit, the interviewer who is looking for exceptions focuses on the days when things were less problematic or painful. Because the patient has kept the record of the better day, the study of the patterns on that day is experienced by patients as a reasonable focus of their care, not a failure to stay on target in looking at the problem.

Even when no day is identified as having an absence or less intensity of the problem, the interviewer can look for days on which the patient was able to maintain their functioning in some area slightly better than on other days with similar levels of the problem. The exception and the consequent solution talk in these situations are about the maintenance of function rather than about the lessening of the problem.

When patients do not have any idea of what they did to influence the exception that has been identified, it is possible to stay in solution talk by looking "downstream" from the exception. The patient can be asked what they are able to do or able to enjoy on the days when things are slightly better that they are not able to do or enjoy on the worst days. Any answer can be discussed for another question or two.

Interviewer: "It sounds like the days of lower pain come pretty much without warning. You can't see anything that you do or anything that you don't do that helps you have a less painful day. What can you do or what can you enjoy on one of your lower pain days that you can't do on a bad pain day?"

Patient: "I can sometimes go for a brief walk, just around the block or up to the corner store."
Interviewer: "What do you particularly enjoy about these walks, when you can take them?"
Patient: "I just like to get out. Sometimes I get to chat with my neighbor for a little while."
Interviewer: "Sounds like you have made some important relationships that you try to keep up when you can. Can you say a little more about that?"

Even if a patient cannot think of anything they do to influence the exception, if they can report the things they do when the exception occurs, they create a brief time to discuss their self-efficacy in those moments. Conversations about their self-efficacy, in whatever context, help patients build a sense of themselves as effective in some area of their lives. The dynamics of memory increase the likelihood of their remembering times of self-efficacy in other areas of their lives. The last question above, in which the interviewer tries out the idea that the patient has built a network of relationships based on the report of her chatting with a neighbor, is an example of looking for a pattern of efficacy when offered an exception to a problem pattern. Sometimes the patient doesn't agree that there is such a pattern and the topic can be dropped. Sometimes the patient agrees, and that pattern of self-efficacy can continue as a topic in future conversations.

The pattern of the exception, like any answer that describes a possible solution, should be documented with a sentence in the note of the visit. It is captured and made part of the information that informs future conversations and treatment. It becomes available for follow-up by other team members in their conversations with the patient. Solution talk can be a greater part of the interaction of the patient with the team when solution examples are documented and shared. All of the members of the team can present themselves as interested in solutions and as adding to their documentation when another example comes up in conversation. None of the other tasks that team members need to do in their interactions with the patient have to be dropped or curtailed because of added solution talk, unless those tasks become unnecessary because of solution talk. It is always easy to get back to the problems that need to be addressed in a visit by saying, "Maybe you and I can keep this (exception example) in mind as we try to get you more of your better days in the future."

Scaling Questions are ways of orienting the conversation to observing small changes, rather than looking for larger changes or resolutions that are unlikely at the time. Having people rate the difficulties of their symptoms on a scale, such as the 1–10 scale of pain, can help to discover exceptions in the problem or in the impact of the problem that otherwise would be unnoticed. Asking a patient "How was your week?" invites an answer that will be too general to bring a story of better days or better functioning to the patient's memory. Asking patients to rate the level of the symptom or of their functioning or to count instances of the occurrence of the problem every day gives access to the patient's memories about the exceptions that otherwise are not available. (For a way of helping patients keep records that can be

the basis of solution-focused conversations, see the discussion of Tracking in the Appendix of Chap. 12).

"What-Might-It-Look-Like" Questions invite the patient to imagine specifically what their experience would be if the change that is a goal should come about. The more vividly the patient can experience in imagination the various aspects of life in the future they would like to achieve, the more they can have access to pieces of those experiences in the present. What-might-it-look-like questions can help in designating short-term goals, long-term goals, and treatment pathways as part of informal conversations with patients who otherwise might be uncomfortable with a "goal setting" meeting. Short-term goals are elicited by asking what event or observation would be the first sign of a solution developing. A long-term goal can be a formulated by asking the "miracle" question. A description of a treatment pathway sometimes emerges from a "how-did-it-heal" question.

An idea of the short-term solution can be elicited by asking about how the solution, or the improvement, would first be noticeable. The patient is asked, "If this problem were starting to improve, what would tip you off that an improvement that wasn't just temporary had begun?" The answer then can be examined further. Has that first indicator of an improvement happened before? Did you or someone else do anything that helped it happen? Has any part of it occurred recently? What will you begin to be able to do if that small change occurs? If the first answer is a bit general or seems to be an unrealistically large step toward a solution, a question that asks about the first element of that change can help define a more reachable goal.

Sometimes when a problem that has had recurrent cycles of being better and worse, the question can be phrased as, "What have you noticed in the past that let you know that the worst part of a bad period was past and you were starting to come out of a bad time and go into one of your better periods?" Simply studying all of the elements of the evolution from a bad period to a good period can make those elements more vivid and more accessible to the patient. The search for a more permanent solution can then be phrased, "What would happen in a better period that would let you know that this better time was going to last longer or be even better than the good periods in previous cycles?" In this situation, the elements that signal improvement can become a short-term goal, and the elements that would indicate a changing for the better of the overall pattern become the long-term goal.

Whenever a patient can articulate what would happen that would indicate that the beginning of a solution was starting, it can be helpful to follow with an exception question. If we know just what would indicate to the patient that things were just starting to improve, we can ask if that event has occurred recently. Often it has happened. That gives an example of a solution pattern to examine in more detail, more solution talk.

Interviewer: "If you were starting to get a handle on your diabetes, I don't mean get everything managed completely, but just the first step, what would you be likely to see happening?"

Patient: "I guess I would start to take my medication more regularly. I often forget and sometimes I just don't feel like taking another pill."

Interviewer: "How many doses in a row would you have to take for you to notice that you were starting to do slightly better at keeping on your schedule?"

Patient: "I guess if I took it morning and night three days in a row, that would be different enough for me to think I was starting to be more regular."

Interviewer: (Clear answer to a what-might-it-look-like question creates an opportunity for an exception question). "Has there been a time in the last few months that you can think of when you took your medication twice a day for three days in a row?"

Patient: "I guess I did when I was at my sister's house. I did four days in a row then."

Interviewer: "What was it about being at your sister's house that made it possible for you to be able to take care of your diabetes a bit better?"

Sometimes when a conversation like the one above is possible, the event that was going to be designated as a short-term goal turns out to have already occurred. Then the focus can be changed from having one occurrence of the event as the short-term goal to looking for multiple occurrences.

The "miracle" question is a way of helping a patient imagine their life in a world in which the current problem has resolved or lost its impact. De Shazer articulated the question in 1988, and it has continued to be used in essentially the same form since:

> Now I want to ask you a strange question. Suppose that while you are sleeping tonight and the entire house is quiet, a miracle happens. The miracle is that the problem which brought you here is solved. However, because you are sleeping, you don't know that the miracle has happened. So, when you wake up tomorrow morning, what will be different that will tell you that a miracle has happened and the problem which brought you here is solved? (de Shazer [19], p. 5)

The term "problem which brought you here" is a place holder for whatever problem is under discussion. Phrasing that problem in a way that makes it possibly solvable can be helpful and grounding in the process. Instead of saying "your diabetes was gone," saying "your difficulties managing your diabetes were gone" might be more possible for the patient to imagine. Instead of saying "your trauma never happened," saying "the power that your traumatic experiences have over your life was completely gone" would make the goal more accessible.

It is important that the question focus the patient experientially on what they would see or hear or think or notice as they went through their day and discovered the miracle. What would or would not occur that would indicate that the problem was resolved. This is different from asking at the start for a list of all the changes that would have occurred. The miracle question should focus on one problem area in the lives of multiply-disadvantaged patients with complex health issues, rather than on a resolution of all problems. The follow-up discussion between the health

professional and the patient about the patient's imagined experience after the focus problem was miraculously resolved can then look at what the impact of that resolution would be on other problem areas. This conveys a picture of the way that, for most people, any significant improvement in one problem area is likely to have positive impacts on other problem areas. That means that as the patient improves in one area, their hope and experience of self-efficacy can be improving to at least a small degree in others.

An example:

Interviewer: Now I want to ask you a strange question. Suppose while you are sleeping tonight and all the house is quiet, a miracle happens. The miracle is that your depression is over. However, because you are sleeping, you don't know that the miracle has happened. So when you wake up in the morning, what will tell you that a miracle has happened and the depression that you have been coping with for so long has gone.

Patient: I guess if my depression was really gone, I would want to get out of bed and go make breakfast for me and my grandson.

Interviewer: What else might you notice as you get further into the day?

Patient: I guess I would be more interested in what my grandson was going to do at school when we talked at breakfast and I would clean up the dishes when I got back from walking him to the bus.

Interviewer: Anything else?

Patient: I probably would go for a walk or maybe call and talk to my sister.

Interviewer: So if you had a morning where you wanted to get out of bed, you liked making breakfast for you and your grandson, you were interested in what he was going to do that day at school, you cleaned up the kitchen when you got back from walking him to the bus and you felt like going for a walk or calling your sister, what would you be telling yourself about how your day was going and about your depression?

Patient: I guess I would notice that I was having a really good day.

Interviewer: What would happen sooner or later that would let you know that your depression was really not coming back, not just that you were having a good day?

Patient: I guess if my grandson had a problem at school, if he didn't do his homework or if he got in trouble and it didn't make me really sad or angry and make me go back to hating to get up in the morning, that would let me know that things were really changed.

Interviewer: Suppose you were doing so much better, how would that help you with your diabetes?

Patient: Well, for one thing, I would feel like getting more exercise because I would like walking. I guess I would feel like it was worth it to do all the stuff I am supposed to do for my diabetes because I would feel like I had more good times to look forward to.

Interviewer: How do you think the disappearance of your depression would affect your grandson?

Patient: I guess he would worry about me less and maybe do better in school.

It is possible for this kind of conversation, exploring the impact of the miracle, to go in multiple directions and to be continued as part of multiple visits. In the process of the conversation, the elements that would be involved in achieving the long-term goal can be enumerated. For the patient in the example, getting up quickly, talking to her grandson at breakfast, getting exercise, being in contact with other family members, and doing a targeted amount of cleaning can be isolated as things to be tracked. To keep the process from seeming impossible, at any point in which a long-term goal needs to be articulated, the term "resolved" could give way to "significant progress." Tracking any or all of these elements can mean to the patient that they watch themselves approach an element of the long-term goal. Always be sure, when reviewing any tracking form or diary that the patient keeps to ask how the patient was able to do as many of the elements of the goal as they were able to do, rather than why they didn't do more.

How-did-it-heal questions are useful after a patient has begun to make progress on a problem. In situations in which there is a good relationship between the interviewer and the patient, sometimes it is possible to help the patient imagine the solution or visualize achieving the goal in a way that helps them imagine the entire pathway to achieving that goal. I have often been surprised at the clarity and specificity of the steps to the goal that a patient has produced in response to this question. When the question works, the steps that they imagine can be incorporated into the treatment plan as the patient's expectation of the course of treatment.

To ask a how-did-it-heal question, the interviewer invites the patient to imagine a time in the future when the problem is resolved and then to imagine telling the story of the journey to the resolution to the interviewer as part of a chance meeting on the street. In the future scene, the patient is characterized as managing their life without professional help in the problem area.

An example:

Interviewer: I know you've been struggling with this problem for a good while and you are just beginning to feel like you are getting a handle on it, but let me ask you to imagine a time in the future after your current efforts have had time to really pay off. Let's imagine that you are able to reach your goal in terms of this problem. You don't have to be working on it anymore. Keeping on track is much easier. You haven't been seeing me or anyone else about this problem for a good while. How long in the future do you think we are talking about?

Patient: I don't know, maybe five years?

Interviewer: So, let's imagine it's five years from now. You reached your goal in this area and you are focusing on other areas of your life. And let's say you and I run into each other on the street or in Walmart or someplace, and we say hello, and I say that I am glad to see you looking so well. And I say, "I haven't seen you in years, you look like you are really thriving, what's working for you?" and you say, "you know that problem we were working on? I pretty much put that behind me a while ago and now I am on to another part of my life" and I say "so

what did you do to make this work, to get to where you are?” What would you tell me? What would be your story of how you got yourself to where you are?

Patient: Well, I guess I would say that first I kept sober finally. That was real important. Then maybe I went back to the job training program and I did the whole thing. And after that I got a job and got my own place . . . got my own place, and from there I started to be able to visit with my kids regularly.

As the patient is telling the story, the interviewer can help make the details richer by commenting on the emotional experience that would likely go with any of the success experiences the patient describes. Comments such as “that must have made you pretty proud” or “I’ll bet your kids were happy about that” help the patient experience each step more vividly and thereby be more specific with the steps that they create.

The conversation can be capped with a statement by the interviewer that it seems that the patient, consciously or unconsciously, has a plan for their future that they have been working on. The interviewer can suggest that maybe it will be pos- sible to talk in the future about how they could use help for some of the parts of their plan and how they are likely to handle some aspects of their plan on their own.

8.3 Solution-Focused Questions and Different Team Roles

Each member of the team can use solution-focused questions in ways that fit the tasks that are part of their role. There is no question that needs to be the sole province of one role or of a particular license. Questions are not inherently medical or mental health in character. Different teams are made up of members with different roles. Teams working with multiply-disadvantaged patients might have more members than teams for patients presenting less complexity. Team members will have varying levels of engagement with different patients and be able to ask different sorts of questions depending on their level of engagement with each. Patients will present widely varying sorts of problems and illnesses, for which different questions will be a fit. The examples below are just to suggest some common possibilities, not to assign types of questions to particular roles.

A medical assistant doing vitals for a patient with hypertension who notices a lower blood pressure than the last visit can ask if the patient had been doing anything to try to help with their BP. If the answer is yes, the MA can say that she will make a note that the patient has been working on blood pressure because the doctor will want to hear more about it. If there is an open conversation (see Chap. 7) between the MA and the doctor in the exam room with the patient, the fact that the patient was making efforts on her blood pressure would be mentioned. If there is no overlap, the doctor can mention the MA’s note before asking about what the patient had been doing for her blood pressure. Passing solution talk from one role to another as part of the patient’s visit sets a tone of respect and engagement that makes the team a positive reality for the patient.

The doctor might use an exception question as part of discussing the pattern of the occurrence of a symptom. Asking about times when a symptom occurred can give hints into what might be causing or triggering the symptom. If the symptom is happening regularly, asking about times when the symptom does not occur might give hints into what tends to prevent or alleviate the symptom. A quick question about whether the patient can identify anything that they or anyone else did that might have helped create the symptom free (or symptom reduced) period can lead to a quick characterization of the patient as already having some success in dealing with symptoms. This highlights the patient's efficacy in the situation and can help support future partnership of the patient.

The behavioral health clinician can use coping questions in engaging patients, exceptions questions in supporting a developing process of change, and what-might-it-look-like questions when they have time to talk in depth about a problem pattern with which a patient is struggling. In fact, most BHCs can spend a good part of their day in solution talk, working on depression, anxiety, substance use, and health behavior change and consulting to other team members.

Care enhancers will probably use coping questions quite a lot. They will be the team members most likely to see the specific ways that the social determinants of health are affecting their patients' lives. That knowledge lets them ask questions about how people have coped with, for example, homelessness, trauma, challenges of the dominant culture, challenges of the culture of the medical system, personal loss, unemployment, or trying to keep a job. In the case of any of these examples of coping, the care enhancer can share a sentence or two with coping story they obtain from the patient with the other team members. Through the brief notes of the CE, the whole team gets more knowledgeable about the patient's strengths and successes in their situation.

8.4 Summary

The methodology of solution-focused interviewing provides a way to start the process of empowering multiply-disadvantaged patients by helping them experience their self-efficacy in relation to their health, a basic step that can help them participate as partners with their doctors and health teams. As members of the healthcare team ask questions that focus patients on their own abilities to find solutions, the perception of these patients about themselves and the perception of them by the members of their health teams tend to evolve. Both sides experience the patient as more capable and tend to experience the team as more perceptive. This lays and important foundation for motivational interviewing and shared decision-making. The transparency of information about the patient in a practice seen in the use of open notes and open clinical conversations creates an important vehicle for sharing the solutions envisioned and achieved by the patient. In the next chapter, we will explore the way in which a solution-focused information exchange creates an environment in which multiply-disadvantaged patients can become activated for improving their health.

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Resources

Solution-Focused Interviewing

Furman, B., and Ahola, T. (1992). Solution talk: Hosting therapeutic conversations. New York: W. W. Norton. A classic book in the field that can be borrowed at no cost with examples of SFI conversations from a broad range of settings and with many types of problems and symptoms. https://archive.org/details/solutiontalkhost00furm