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Articles in this issue:

What Directions For Future Research?
Alasdair J Macdonald signposts some recent research

Solution Focused Approaches to Speech Therapy and the Health Service
Kidge Burns explores the usage of solution focused approaches in the hospital setting

Steps Toward Mastering Solution Focused Brief Therapy
Maureen Smojkis reflects on the MA course in SFBT at the University of Birmingham

Dazed and Confused – A Survivor's Account of Solution Focused Supervision
Clare Firth talks about the experiences of receiving solution focused supervision

Theory and Solution Focused Therapy
Paul Hanton raises questions about the nature of theory in solution focused approaches

Also in this issue:

Editorial

Correspondence

Association News
Details of what the UKASFP sub-systems have been up to

Book reviews

Solution Gnus
All your questions about solution focused working answered

Member News
Information on what our members are doing and plan to do

United Kingdom Association for
UKASFP
Solution Focused Practice

I must admit that when someone had the bright idea that the UKASFP needed a newsletter and I volunteered to have a go, I had absolutely no idea what I was getting myself into. The learning curve has been steep, but of all the surprises that have awaited me on this journey so far, the biggest has been the demand for copies outside of the UK. When issue one of *Solution News* was finally finished, we posted to the international SFT-L discussion list to see if anyone would like a copy of our fledgling association's newsletter more out of politeness than out of any expectation that there would be real interest. Over 200 requests from five continents later, I'm beginning to think again.

I guess I'd temporarily overlooked one of the key things that attracted me to solution focused working in the first place, which is its practitioners' overflowing enthusiasm to share ideas, learn, and to approach both their own and other's practice from a curious, 'not-knowing' perspective. It is the peer support and enthusiasm from fellow 'solutioneers', as much as the joy of learning from our clients, that I believe acts as an antidote to burnout for SFers.

This issue contains more articles by some enthusiastic practitioners. In the following pages you'll find practical ideas, thought provoking discussion of what we are about, and personal accounts to make you smile, nod your head in appreciation, and just possibly shriek with laughter.

As I suggested in the last issue, feedback and contributions are the lifeblood of this sort of publication. Let us know what you think of this issue, for good or ill, or send (or even just talk to us about the idea of sending) contributions in the form of letters, questions, updates, reviews or full-blown articles, to editor@solution-news.co.uk.

Best wishes

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What Directions For Future Research?

Alasdair J Macdonald signposts some recent research, and provides ideas for future projects.

There has been much and varied research into solution focused therapy over the last few years. This is perhaps unsurprising for a therapy that was constructed using a research methodology, and where each development has been based on client feedback.

In terms of outcome research, to date there have been three good randomised controlled trials and ten comparison studies conducted, as well as follow-up information gathered on over 1100 cases. Although developing a research base is not the 'be all and end all' (plenty of therapies have an evidence base, but plenty of therapies have none), if we want to influence the scientific community then we need to continue to pursue further useful research.

> **"If we want to influence the scientific community, we need to pursue further useful research**

The European Brief Therapy Association (EBTA) has set up a multinational research project, which so far includes four countries. A manual providing a research definition of solution focused brief therapy (SFBT) has been developed for the project, which is meant as a starting point rather than a 'strait-jacket'.

The EBTA project aims to provide evidence to support Jon Prosser's hypothesis that client scaling is equivalent to objective measures. The study uses the OQ45 symptom/ function questionnaire (which is designed specifically for psychotherapy outcome assessment), and the therapist's Global Assessment of Function rating from DSM-IV. Data from our seven cases in Carlisle support Prosser's hypothesis so we hope that the whole study will do so. We also hope that therapists who use other models will take part in comparison studies using the EBTA research design.

Future studies might examine deconstructing methods such as the formula first-session task, or might compare SFBT with SFBT plus one new question (much as Steve de Shazer and Insoo Kim Berg started out). Alternatively, a study might look for differences according to whether pre-session change is present or absent (compare Beyebach et al, 1996.). Do clients see a connection between pre-session changes and success in treatment?

Another interesting area of research might be to look at the pre-suppositional questions such as "What's been better?" that are often asked in second and later sessions. Do these

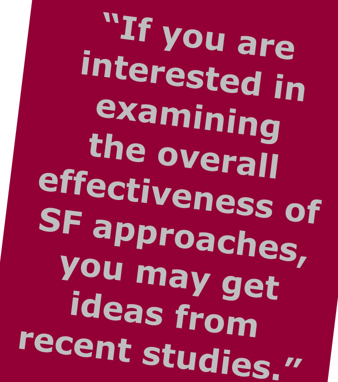
Alasdair Macdonald is a consultant psychiatrist and trainer. He is also the president of the European Brief Therapy Association (EBTA).

increase the effectiveness of therapy overall? It has been suggested that the miracle question is more effective if exception questions are asked first (see McKeel, 1999); is this true? Many skilled practitioners do not follow this sequence.

Research using no-treatment conditions may not be ethical now that there is good evidence for the effectiveness of SFBT. However, waiting-list controls can be used, who are then offered therapy later. Alternatively, clients can be used as their own controls by applying objective measures for a period before therapy starts. Multiple types of outcome measure will improve credibility and reliability. For example, one could use combinations of ratings and replies by clients and therapists, objective questionnaire measures, and hard measures of outcome such as re-offending, relapse or increase in use of health care services. Relapse and therapy cost are of particular interest to managers and commissioners of services because they are seen as measures of outcome and cost-efficiency.

The research on psychotherapy generally shows that the therapeutic alliance is central to good outcome, and that clients recognise this (Seligman 1995; Wampold 2001). Another useful area for research therefore might be to examine what identifies a good alliance in the client's mind and in the therapist's mind, as well as whether all the clients present need to believe that there is an alliance. An interesting example of research on this topic has been provided by Beyebach and Carranza (1997), who identified specific interactions that predicted drop-out by clients. In a similar vein, several studies have shown that clients do not even recall the techniques used by therapists. The Lonnen team in Stockholm had clients interviewed after solution focused therapy by someone from Tom Andersen's Norwegian narrative team. He found that whilst clients liked therapy and found it useful, they tended to have no recall of techniques such as scaling or the miracle question.

If you are interested in examining the overall effectiveness of solution focused approaches, you may gain ideas from recent studies. For example, in a recent study in Finland, Knekt and Lindfors (2004) conducted a major randomised comparison trial examining the effect of four forms of psychotherapy on depressive and anxiety disorders. These comprised SFBT, short-term psychodynamic psychotherapy, long-term psychotherapy and psychoanalysis. The one-year follow-up of the SFBT and short-term psychodynamic therapy groups has now been published. Ninety-three participants received solution focused therapy and ninety-eight received short-term psychotherapy from practitioners with an allegiance to the style offered. All clients had had problems for more than one year. Thirty to fifty per cent had full recovery at seven months as measured by a battery of tests. Unfortunately, the study provides no figures about clients who only partially recovered.



These published findings suggest that solution focused therapy worked more quickly for participants with depression. Short-term psychodynamic therapy was better for 'personality disorder' as diagnosed by the therapist, although personality questionnaires did not support this finding. Might this be because diagnostic practices by therapists differ in the two schools of thought? Personally, I have become reluctant to diagnose personality disorder since I became a solution focused therapist, as I have found that many clients who appear strange at first turn out to be able to function well and competently once they have resolved their immediate problems.

The solution focused therapists in the study provided on average 10 sessions over 7.5 months, whilst the psychodynamic therapists

provided 15 sessions over 5.7 months (fifty per cent more sessions!). This raises the question of whether it is length of time that matters for change, or number of contacts with the therapist. The long-term and psychoanalysis comparison data are yet to be published.

We have also recently published a summary of three of our own previous outcome research projects (Macdonald 2005), which were one-year follow-up studies based on feedback from clients and their GPs. In all 170 clients or families were referred, of whom 153 were seen and 118 traced for follow-up. There was a good outcome for 83 (70%) with a mean of 4.03 sessions. Twenty-nine (25%) had only one session. Differences in economic class did not affect outcome. People with longstanding problems (present for three years or more) did less well than those who had had their problems less time. Discharged clients did better than those who dropped out of treatment (which contradicts existing psychotherapy research). New problems developed less frequently in the good outcome group. Outcome was not predicted by diagnosis, age, gender, or whether the client attended alone or with family members.

Finally, if you want some really challenging ideas to research, in Words Were Originally Magic Steve de Shazer says that interviews of half an hour are enough to produce a relevant closing statement and to facilitate useful change, even if the content is not enough for the therapist to know all the details of the problem and goals. He suggests that goals are related to the problem, while the miracle and scaling are related to the solution. These are all propositions that could be tested while following your usual clinic method.

There are many fascinating topics for research into solution focused working waiting to be explored. For those who wish more information on research and useful areas for investigation, I can recommend Jay McKeel's web article of 1999 and Lambert's 2004 textbook.

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Solution Focused Approaches to Speech Therapy and the Health Service

Kidge Burns explores the positive use of karaoke (and other resources) in the hospital setting.

Kidge is a speech and language therapist based at the Chelsea and Westminster Hospital in London. She works with a variety of clients with acute neurological disorders, chronic disease (such as Parkinson's disease) and clients who stammer. Her book 'Focus on Solutions: A Health Professionals Guide' was published earlier this year.

The Department of Health (2001) talks about 'The expert patient. A new approach to chronic disease management for the twenty-first century'. In January 2005 the DoH reiterated the importance of encouraging people with long-term conditions - more than 17.5 million of them in the UK - to manage their own care more effectively. So is the language already in place? How client involvement is influencing service development in an acute NHS hospital is the subject of this article; the Speech and Language Therapy (SLT) department at the Chelsea and Westminster Hospital has noticed change over time in the way we manage both the inpatient and outpatient caseload as a result of incorporating a solution focused approach.

> **"It is the client who ultimately determines the impact of the health condition on their lives"**

Participatory models of decision making can allow clients to decide, for example, how often they need to be seen by a professional. We have found that there has been a significant reduction in the number of sessions requested by our clients with voice or stammering problems. They are able to see that it is the time between sessions that matters when they are pursuing their own goals, so that there may not need to be a prescribed number of sessions on a weekly basis to achieve a satisfactory outcome. Assessments and reports which include client perceptions as to how they are coping, is further recognition of the importance in working collaboratively with our clients to facilitate change.

To provide an example of this: in the past, a client with voice difficulties would have had a report sent to their GP which might have included a list of the problems encountered, (a detailed description, say, of a hoarse voice with crackles, pain experienced and/or depression), followed by a recommendation that the client have a package of voice therapy focusing on relaxation, breathing and resonance. Now, however, the report from the SLT will read quite differently: "I note the findings of.... Mrs H has noted that her voice is better when she talks less and takes more breaks. On a scale of 0 to 10 with 10 standing for Mrs H being entirely happy with her voice and 0 standing for opposite of that, she gives herself a 5 and is aiming now for a 7. She will do this by concentrating on her posture, resting and practising stretching exercises. These are realistic goals which have been identified by Mrs H in the session."

As part of the multidisciplinary stroke team (the communicative

process being one of the areas that can be affected by brain damage as a result of a stroke), we are able to use scales and a future focus to help people return to participation in life more effectively. Someone's 'performance' may not change but their perceptions as to how well they feel they are managing to live with a stroke can, and focusing on this can be an important shift away from the medical model, where attention tends to be on symptom removal.

So many of our clients are preoccupied with their spoken language but as SLTs we are encouraged to look for 90% of a message being conveyed non-verbally. A solution focused approach not only helps the client view their own internal processes, but also their immediate communication partnerships and the environments that form part of their life. Steve de Shazer's use of the miracle question says it all: 'what would you or your partner notice different in the morning, without words?'

The national clinical guidelines for stroke (RCP, 2004) acknowledge the importance of involving clients in goal-setting and giving them the opportunity to practice functional activities in rehabilitation. There is recognition that 'disturbance of mood is common after a stroke' and medication is recommended if depression is severe. However, "minor depression should be managed by 'watchful waiting'". How solution focused approaches can work in this context is best demonstrated, as always, by giving a case example.

Veronica, 53-years-old, is admitted to hospital following a stroke. She has difficulties with movement, eating and drinking, and communication which require input from all the members of the stroke team. Within a short period of time her ability to benefit from rehabilitation is affected by her mood in that she frequently becomes tearful and does not carry out exercises recommended to promote change. Veronica has many concerns about her ability to speak both English and her mother tongue. The SLT uses scales to measure change since admission to hospital and to help her establish evidence of further progress:

V: *My speaking needs to be sharper. I'm still locked [in].*

T: *So how will you know that you're less locked in…. that things are a little better?*

V: *I love songs. When I'm ready to do singing I'll do it.*

T: *That sounds like a good idea!*

The SLT reports back to the stroke team the words and phrases that Veronica has used and how she perceives the ability to sing again as an important goal for the future. A week later Veronica tells the SLT she has been singing karaoke. She has found it very encouraging as she is able to read the words and sing perfectly. The nurse confirms that Veronica's family has brought in a karaoke machine and that there is a noticeable improvement in her mood.

Seeing Veronica's expression when describing this event is rewarding enough. A further magic moment for the therapist occurs when reading what the medical team have documented in their notes. Alongside the blood pressure levels and temperature readings is the following: "patient sang karaoke over the weekend".

It is this recognition of the importance of well-being and the subjective aspects of illness that highlights a change in how the medical profession are working together with clients, carers and families in our service.

In hospital we see clients who are suffering from the physical effects of acute neurological events such as a stroke or head injury as well as chronic conditions such as Parkinson's disease. Our theoretical knowledge and professional experience can help predict outcomes but it is the clients who ultimately determine how much the problems impact on their lives. Acknowledging this means we can become less directive in our work and follow the client's lead.

A few weeks ago a colleague said: "Since being trained in solution focused work I recently found a case much easier. Normally I'm a little nervous of these clients as I feel I'm not an expert on their condition. But this

time I realised I don't have to give them all the answers. They came up with all the strategies and resources they've been using. It went really well." Acknowledging distress caused by life-changing events is important and a solution focused approach helps encourage both professionals and clients to feel they are competent to deal with these issues. Ward rounds, team meetings and case conferences provide us with the opportunity to talk about positive outcomes and how the ideals of client involvement can be brought in to everyday practice. Solution focused language enables more effective communication across disciplines where a narrow focus on dimensions of impairment does not.

There is a need, however, for a corresponding change in the academic curriculum towards more interactive techniques that can be used by health professionals in the acute stage as well as the later stages of treatment; a need for training in solution focused brief therapy!

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CORRESPONDENCE

We welcome your views and comments on any article in Solution News, the UKASFP, or on any other solution focused topic. Send your correspondence to letters@solution-news.co.uk, indicating clearly whether you intend your correspondence for print or solely for consumption by the Solution News team.

Joe Windsor writes:

In SN #1 Evan George suggested that the SFBT philosophy chimed with our less deferent times. Attitudes had changed and the professional was no longer the 'expert'. Today's professional needs to deliver what the 'service-user' specifies. But why did it need saying?

A year in hospital taught me much about health professionals and their hierarchy. Our approach should be a solution focused endeavour, with the Client as expert in themselves. The Therapist is an egalitarian, not an authoritarian superior. The Client and the Therapist form a team empowering the Client to deliver their own solution. When I first meet a Client I present myself as a Coach, an equal, someone to help them succeed for themselves.

So I researched and two problems emerged. Firstly, I have ALWAYS written the word 'Client' with a capital C. A psychological proposition defining my view of my Client. Then I looked through various references and many SFBT's use a small c. BIG THERAPIST, small client. I explored how 'outsiders' perceived Therapists, many associated with big Agencies. My sample was small so may not be wholly representative, but the perception (and we live in the world of perception) was of Authoritarian Therapists.

Evan George should have been right. I 'service' my Clients as a Coach, not a figure of authority. Somewhere out there is a discontinuity between what SFBT should be and what it has, in places, become. Surely this is a matter of fundamental significance to us all? NOT because I think I'm right and others are wrong. But attitudes, pressures– whatever – may be deflecting the reality of SFBT. PLEASE tell me I'm wrong – nothing would bring me greater pleasure.

Over to you.

Steps Toward Mastering Solution Focused Brief Therapy

Maureen Smojkis reflects on her work leading one of the most in-depth courses of study available in solution focused practice.

I was surprised and very pleased when invited by Bill O'Connell to become involved in the MA in Solution Focused Brief Therapy in 2001. Bill had developed a very innovative approach to part-time education in a subject that did, and continues to, underpin my own value system and practice. The MA is aimed at people who are working in a capacity in which they can use a solution focused approach, and many who join the course have a vast amount of experience and pre-existing professional qualifications in areas such as Social Work, Psychology, Counselling, Teaching or Nursing.

Bill O'Connell's organisation and structure of delivery of the MA continues in its original form. Students attend the University for seventeen days per academic year, in blocks of three to four days. In between there is regular online discussion and internet contact. Bill's enthusiasm for solution focused practice runs through the veins of the course; he is definitely a hard act to follow. I hope that in this (the fifth) year the course has evolved in line with his views, and with the comments and suggestions made by the people who have taken part.

Part-time education for people who are employed full-time is not an easy option, and the collaborative process of education (with the student being the expert in their own learning) has to be key to studying on a part-time basis at this level. Each group of people who access the MA bring with them their own experience and interest, which makes the learning process live and dynamic; it is never dull. The participants value the sharing with peers of knowledge about and uses of the approach, but mostly they continuing to learn from the people who use the services in which they are employed.

"the reason most people sign up is their interest in the process and skills"

One of the draws of solution focused practice for those of us who work within large traditional organisations is the exploration of language and the challenge it poses to the use of diagnosis. On this front, as on others, the diversity of the MA groups certainly adds to the liveliness of debate. In addition, the research that has been and continues to be produced by the people participating in

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the programme adds to the existing body of knowledge and helps to bring solution focused practice to a wider audience.

It was while working for a Psychology department as a Counsellor in Primary Care that I first became acquainted with solution focused practice, at a time when it had captured the interest of many of the Counsellors whose remit was to work briefly. I had worked as Nurse and Counsellor in the NHS for 20 years before I made the move into the University. However, the integration of theory and practice has always been central to my work, and I find I am now able to put this knowledge to good use on the course. I now divide my time between the University and the local mental health trust where I am involved in multidisciplinary continuous practice development and offering clinical supervision to individuals and groups. Solution focused practice is integral to these activities, and reflective teams are a welcome and central feature.

Leading the course can be a challenging experience when the reason most people sign up is their interest in the process and skills. The academic requirements of the course (to produce written work underpinned by relevant literature) sound less exciting. For this reason the majority of the time at the University is spent on skills, and the theoretical component is largely done through reading, discussions online and the lively contributions to the bulletin board. The written component does offer the opportunity to critically analyse other's writing and contributions as well as to develop opinions on practice and development. The value of linking SFBT theory to practice is embedded in the organisation of the modules and in the academic requirements. The enthusiasm and diversity of the participants on the course always ensures that no two assignments on one subject are remotely the same; much of what is written is worthy of and would be of interest to a wider audience.

My best hopes for the future of education and training in SFBT are to carry on down the same road, as my experiences from the MA and elsewhere tell me that we seem to be going in the right direction. The past ten years has witnessed a large growth in the availability and variety of education and training offered in solution focused practice in the UK and I am glad to be a part of this process. The learning opportunities for those who have an interest in SFBT are vast and this makes prospects for the future even more exciting.

Let us know what you think of a book...

Solution News has a number of books available for members to review. If you would like to review one of the books below, or another book, or if you would like to make a book available for review, please contact books@solution-news.co.uk.

Books currently available:
- Solution Focused Stress Counselling by Bill O'Connell
- Handbook of Solution-Focused Therapy. Edited by Bill O'Connell and Stephen Palmer
- Solution-Focused Therapy (2nd edition) by Bill O'Connell.

Useful web-links

UKASFP web-site is at www.ukasfp.co.uk

Join the UKASFP national discussion group at www.smartgroups.com

European Brief Therapy Association web site is at www.ebta.nu

The St John's (SFT-L) international discussion list is at http://maelstrom.stjohns.edu/CGI/wa.exe?SUBED1=sft-l&A=1

Dazed and Confused – A Survivor's Account of Solution Focused Supervision

Clare Firth tells her personal tale of adventure, culture shock and extreme personal / professional development at the hands of an SF supervisor.

Having caught the Solution Focussed Brief Therapy (SFBT) 'bug' when I qualified four years ago, but with most of my training to date being around problem-focused models and with working in a department dominated mainly by Cognitive Behavioural Therapy (CBT) I have been keen to get some SFBT supervision in the hope that this would help to improve my skills and help me along the road to becoming an SFBT 'expert'. Last year I managed to arrange some supervision sessions and I thought I'd write about my experience; largely in the hope that it might inspire people who are new to SFBT, but also because I found the whole experience interesting and hope that you do too.

"Where was all the advice? Surely 'Keep doing what you are doing' couldn't be it?"

Having located a supervisor I arranged three, hour-long supervision sessions, each one being one month apart, with the anticipation of needing to arrange more afterwards. Not knowing quite what to expect from the first session, I remember it was a relief when my new supervisor came across as being human and put me at my ease. He then asked about my hopes for our meeting. This somehow struck me as being different to how previous supervisory relationships had started, until I twigged that solution focused supervision was bound to start this way! A-ha!

I remember mentioning something about hoping to feel more confident in my SFBT skills and then I found myself starting to do a lot of 'complaining' about some of my difficult cases and much advice-seeking. During all this my supervisor patiently listened to, validated and empathised with my difficulties, and asked how I'd coped with them. This carried on until I realised I'd spent most of the session talking about my problems at great length!

There was barely enough time left for my supervisor to respond, which he did in the form of some specific positive feedback. Again I had to remind myself that SFBT practitioners were prone to giving compliments, but not being used to such direct positive feedback it was a relief when I also received some of the advice that I'd been expecting from the meeting (of course only after first checking out that it was okay with me to do this)!

I recall leaving this first session in a bit of a puzzled daze. Had I really mentioned some cases that were going well? What was all that about strengths? Where was the lengthy advice

Clare works as a Clinical Psychologist in a CAMHS team working with children and families age 0-18. She has special interests in primary care, paediatrics and parental mental health issues.

and detailed teaching relating to different diagnostic conditions? Had we really been having the same conversation? Upon returning home I anxiously wrote down the bits of SFBT advice in case I forgot them and noticed a strange sort of excited, buzzy feeling, but quickly re-interpreted it as being due to arriving home and looking forward to my dinner!

I arrived rather gollum-like back at CBT-land the next day, clutching my precious SFBT pages of wisdom with a new found sense of optimism. Now I had some excellent 'answers' to use with my difficult cases! However, over the next few days I started noticing something unusual happening with my own behaviour. Firstly I found myself starting to notice the aspects of my work I'd been complimented on during my meeting with my supervisor. I also started noticing some new things that were going well during sessions that I hadn't even paid attention to before, including the times when SFBT techniques were having a good effect.

The strange buzzy feeling also kept returning over the next few weeks as I sometimes found myself smiling and laughing during sessions, and I even found myself starting to look forward to meeting up with some of my clients! Occasionally I emerged from a session feeling really excited about the conversation we'd been having!

This strange behaviour continued over the next few weeks. Feeling rather paranoid at this stage, I tried to hide my SFBT skills from my colleagues. From time to time, however, I'd let slip about being rather hopeful about my clients abilities or enthusiastic about a client's strengths, although when this was met with puzzled looks and suspicious raised eyebrows, I soon learned to keep quiet!

One month later... supervision session two

By this time I was finding that my use of SFBT skills was beginning to fade and I was finding myself reverting back to my old CBT style. However I arrived at my supervisor's room feeling positive and hoping to again get some more advice about difficult clients I'd encountered in the meantime. I'd even proudly prepared a list of difficult cases that I wanted to discuss. I tried not to be taken aback therefore when the first question I was asked was, "Tell me what's been going better in your work since we last met?" After again remembering I was in solution focused supervision I managed to suppress my difficult cases and talked instead about what I'd noticed going well during the past month. My supervisor then used further SFBT questions; "Tell me about a case that worked well?", "How did you do that?", "What have you learned about yourself from that case?", "What have your colleagues noticed about you that tells them things are going well?", "What else?", "What else?" , and "What else?"!

Before I knew it we were approaching the end of the session without a complaint in sight! I tried to listen carefully to my supervisor's feedback and tried not to look too surprised this time when the compliments were delivered. I then noticed that the supervisor was signalling that our time was up but found myself puzzling about something that I felt was missing. Where was all the advice? Surely that little sentence at the end, "Keep doing what you're already doing" couldn't be it? Whatever would I write down in my SFBT little book of tips?

Something else strange happened too. I was asked to think about whether I would need the third supervision session. I had thought we would be meeting regularly for the foreseeable future (or until my retirement at least). I looked carefully at my supervisor but couldn't make out whether or when he thought I should come back, so not wanting to outstay my welcome I left the room.

On the way home, I began reflecting on what I'd talked about regarding the cases that were going well, and all the difficult clients I'd been thinking about before supervision faded into the background. This continued back at CBT-land where I found myself starting to apply some of the SFBT principles I was already using in my better cases to help with some of my 'difficult' cases. Sometimes whole days went by without having to consult my precious book of SFBT wisdom! The noticing

behaviours were also back again, this time with full force. I was again noticing the things I'd been complimented on and becoming more reliant on the positive feedback I was getting within sessions rather than on our routine end of therapy evaluation.

The buzzy feeling also reappeared making me say cheery hellos to the receptionists and greet my clients with warm welcomes. I again found myself enjoying my work more and becoming more relaxed during sessions, and was again looking forward to seeing my clients. This time I couldn't help my SFBT behaviour spilling into my conversations with colleagues. I found myself not caring anymore about their puzzled looks at my strange use of language, or by their concerns that I was being indoctrinated into a strange cult!

Four months later…

Over the next four months my positivity towards the model has remained. I actually found that I didn't need the third supervision session, as I've been able to draw on what I'd learned about my own skills from the first two, and have been able to rely on these so far when I need to. My increased self-reliance has allowed me to reduce some of my more problem focused activities and this has in turn freed up time to spend doing more SFBT work, providing greater opportunity to practice my SFBT skills, do more of what works and gain more positive feedback from my work, further energising me to see more clients.. and so on.

I was surprised how quickly I found the meetings useful and helpful in reaching my goals, although I recognise that this may have been partly because I was already socialised into the model. Nonetheless, by being brief, time-limited and short-term, I imagine SFBT techniques might have real implications for efficiency of CPD delivery within the NHS, as well as for job satisfaction and burnout (judging by my increased enthusiasm and enjoyment).

In line with SFBT principles, my SFBT supervision experience has definitely been based on collaboration, competence and respect. In listening and validating my initial 'problem talk', I felt heard and understood and more empowered and motivated. Thinking and talking about my better cases helped me to recognise what was going well and prompted me to notice these things on returning to work. In assuming that I had existing strengths and in locating and amplifying these I was helped to meet my original hopes, i.e. to feel more confident in my SFBT skills. The well-timed and genuine compliments were energising and re-oriented my perspective on my own abilities. Furthermore, assuming that I already had the knowledge and resources further increased my own sense of empowerment and self-reliance, as did letting me take the responsibility for how many sessions I would need.

In these respects SFBT supervision for me has proved synonymous with notions of SFBT client work, and has provided real insight into certain aspects of the client-therapist relationship. It has given me new-found courage to keep persisting with some of the more unusual questions and techniques, and to trust more in the model.

Does this all sound too good to be true? Well I guess I still have my difficult days, when I feel more tempted to cave in and use advice-laden problem-based therapy or dive into the DSM-IV handbook. But I guess I'm now much more likely to keep trusting in the techniques of SFBT and to remember to keep doing what works. Luckily I've managed to retain the bridges into other therapies, and I often venture forth for meetings about shared land/boundaries. I even get my own visitors from time to time. Every time I venture out, however, I'm struck by how quickly new developments arise and how many posters there are advertising training in some new therapy development or other. It's usually a relief to come back to my own SFBT dwelling, knowing that I won't be required to keep up with a bottomless pit of training and knowledge. It's also good to know that I can approach my supervisor at any point if I need a 'top-up' and I'm also looking forward to attending further SFBT 'refresher' events in the future!

ASSOCIATION NEWS

A round-up of the work of the *UKASFP* sub-systems

Steve Freeman provides an update on the general committee's doings.

At the most recent committee meeting we considered, among other things, what the general committee had done in its first ten months, and what needed to be done next. Here is a précis of the things which came to mind:

- A need for regular meetings and communication, both within and between the committees
- Working groups for specific tasks/issues may need to be formed in the future (as was the accreditation committee)
- Consideration of composition of general committee - both the job descriptions and the commitments required of those elected
- The need for a new post of National Development Officer to liaise with external agencies to promote SF practice
- The administration of the next committee elections
- Taking the first steps toward developing a buddy system for the association
- An action plan to recognise & include those who use solution focused approaches in non-therapy areas
- The development of newsletter and web site.
- A review of our financial position (summarised as healthy but not wealthy)

In short we have followed the model we believe in; we have tried to avoid providing directive leadership, but instead done what we hoped was just 'just enough', taking a non-expert stance to work on co-constructing an association with the membership and colleagues.

Dominic Bray & Ian Smith summarise the accreditation committee's recent work.

The committee was formed with the specific task of generating a list of options for accreditation (including not accrediting) and they have now completed this job and disbanded. They came up with a list of nine options that they have now passed on for voting on by the membership. All members should have already received a voting pack detailing these options. Votes need to be in one hour before the AGM on 17th June and the result will inform next year's general committee on what option to take further.

Janine Ross gives us the latest on the conference committee's labour of love.

The organising committee is pleased to say everything seems to be going to plan and on schedule for June 17th!

Workshops will be allocated on the day – there may be limited numbers due to presenter or room constraints so try to get there early as it is first come first served!

There will be the opportunity to share information, renew memberships and buy books again, as well as enjoy networking and catching up with friends old and new over lunch. The night before the conference for those who want to meet up you are cordially invited to Grey Friar's on the corner of Friar's Gate (it is a Wetherspoons) pub.

I look forward to seeing you all there!

Theory and Solution Focused Therapy

Paul Hanton looks at how not having a theory might mean having a theory!

Disclaimer:This article is only my view, and it is written specifically to encourage debate, so please feel free to respond, as I look forward to learning and discussing.

When the person new to solution focused approaches starts to read about Solution Focused Therapy (SFT) in journals, books or on the internet, it is easy to see that many leading proponents of SF approaches (with a few notable exceptions such as Lipchik, 2002), take an atheoretical, or even an anti-theoretical stance. One of the questions that I get asked regularly on courses that I run is "Is it true there is no theory in SFT?" (or similar questions). I usually answer with something like "certainly some people subscribe to that view, I prefer to look at some underlying values born from experience". What a cop out! I was caught out once when discussing SFT with someone over lunch on a training event. I had suggested that solutions do not always have to be directly connected to the problem. After some debate they said to me, "surely that is a theory?"

"There are many many different, and sometimes contradictory, definitions of theory"

My own understanding of theory is twofold:

Firstly, at a scientific or empirical level it is a set of assumptions that are to be or have been 'proved' by research and/ or causal effects of said theory. That all gets a bit complicated for my liking and is open to interpretation, bias, and zeitgeist. Secondly, and the way that I look at theory, is this; it is an explanation of what the phenomena and/or intervention is and how it might be applicable. This definition encompasses even sets of beliefs and assumptions that are born out of experience, feedback and, testing.

Other definitions of theory:

"Theory: N an explanation or system of anything; an exposition of the abstract principles of a science or art. An idea or explanation which has not yet been proved, a conjecture; speculation as opposed to practice…" etc. The Chambers Dictionary

"an explanation, a systematic account of relationships among phenomena" (McMillan & Schumacher, 1984, p. 11)

This is where problems start. There are many many different, and sometimes contradictory, definitions of theory.

As someone that believes that much meaning is derived from

Paul is an independent trainer and consultant, mainly in the substance misuse field, and works part-time in an NHS Psychology Department. Paul is currently submitting his research for the M.A in SFBT at Birmingham University, and has contributed a chapter to the 'Handbook of Solution-Focused Therapy' (O'Connell & Palmer (eds.) 2003, Sage).

language, and language develops within and due to personal and social constructs, whether or not 'theory' exists in SFT is a stance that I feel may benefit from further exploration and debate, and certainly a stance not to be taken at face value. I am often troubled by the discussion and debate surrounding theory and SFT. I agree with those who state it is not the theory but the practice that matters in SFT, and that to have a theory would detract from the uniqueness of each person we see and mean that they may have to 'fit'. However, I also feel that there is a clear set of underlying assumptions or foundations that guide us, such as everyone has a preferred future, the miracle question is helpful, etc.

I am also troubled by what people mean by 'theory' when they take an atheoretical or anti-theoretical stance. Surely as social constructionists we accept that different people interpret the word 'theory' differently, so we can't all be wrong or right.

So, does SFT have a theory? We can play with words and argue for and against the notion of a theoretical standpoint, but there are some underlying assumptions or foundations, which from the outside (of the SF community) look pretty much like theory.

There are clear statements in SF texts that suggest that SFT interventions and practice does not subscribe to, or are not 'deduced from existing theory', (De Jong & Berg, 2002, p.276). However, by believing that all the people we see will have a preferred future, and are always 'motivated for something' (George, Iveson & Ratner, 1999, p.23), and by using a number of interventions to help them realise this (in particular, the miracle question) we will be helpful. Is this part of a theory, or is it an assumption, or is it just what we do?

We believe that amplifying positive change, looking for exceptions, scaling, strength talk and other interventions will prove to be helpful for the people we see, based on experience of ours and others' practice, and increasingly on the research evidence that points to this. Is this a theory? And, if we think something will work, and then find out it does, does that support the theory?

Often when I visit SFT message boards I read some wonderful insights and some complicated explanations of how, why, and what seems to work, some of which have been gleaned from past and present therapists. Often people talk of the origins of SF interventions and the work of various individuals and/or teams. To me, all this sounds like theoretical foundations or underpinnings, though, as I have alluded to earlier, even the word 'theory' is open to interpretation. Whilst it may appear simple, I believe that SFT practice is in fact very complex, and looking deeper into some of our influences it does get rather theoretical, particularly around the whole area of its social constructionist philosophy.

In conclusion, I don't really know whether to say SFT has a theory or not. It certainly has a set of underlying assumptions/foundations about what works, and these assumptions or foundations are being confirmed by the growing body of SFT research (supporting the theory?). Indeed, O'Connell (1998) talks about the original Milwaukee team members (including de Shazer) testing experimental interventions, or (my words) having a theory about what would work.

To believe that a set of SF questions or interventions will (more often than not) prove helpful for the people we see, to believe that everyone has a motivation for coming too see us, to believe that the use of language in particular ways is more helpful than using it in other ways, all indicate a theory of sorts. However, acceptance that we come from a not-knowing position regarding the people we see, and that we will tailor our interventions according to each individual's unique needs, suggests to me that like Milton Erickson we have different theories for each person we see.

The difference for me from other (more theoretical?) approaches is simply that I only really know what is being helpful if I ask the person that I am seeing. To that end I usually ask that person at the end of the first

and (more often than not now) subsequent sessions, questions such as:

"On a scale of 0 to 10, where 10 is most useful and 0, not useful at all, how useful/ helpful did you find this session?"

Dependent on the reply, I might then ask:

"What do you think would be a sign that the next session was slightly more useful?"

Oh oh……..I thought that this kind of feedback might work, and it does! Have I just developed a theory, or now that it's proved has it ceased to be a theory?

Answers on a postcard please……………

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BOOK REVIEW

Focus on Solutions – a health professional's guide. By Kidge Burns. Whurr Publishers, 2005, pb, 168pages. Review by Carole Waskett

The health professionals I work with are educated, thoughtful and caring. They want the very best for their patients, and they use all their considerable skills to that end. I think many of them will find the language skills described in this book invaluable. For while they are practising their technical skills in any area, practitioners are also having conversations with their patients.

The author demonstrates ways of talking which both empathise closely with the patient, and help to open possibilities for them. This will sound familiar to those who work in an SF way. In this book there are many examples of helpful conversations, interspersed with clear explanations of the basic approach underlying them.

Because Kidge Burns is a speech and language therapist, she naturally takes examples from the world of stammers, strokes and neurological illnesses. The solution focused questions and conversations she writes about are helpful for any professional with any patient; even those with very little spoken language. Many of the ills described are long-term difficulties; often, there is no 'cure'. Even so, Kidge shows how to elicit heartening self-descriptions of strengths, abilities and competencies, rather than problems and deficiencies.

There are chapters on patients in acute settings, those living independently, and family and group work, as well as a helpful discussion of the collaborative Malcomess care aims model of evaluation. There are many 'key points' boxes - things to remember if you don't remember anything else.

Quote from a therapist (p.137):
"Since learning about SFBT I feel I don't have to 'cure' people any more. I know it's about what they do with their circumstances that really matters".

This is a good solid paperback, neatly and elegantly produced, and clearly and accessibly written. Just for a moment, imagine a whole NHS Trust which sought and nurtured competencies and strengths in all its patients and carers, its staff and managers! So please, buy this book for yourself, your team, your department. Or if you teach health professionals, then put it on your reading list. Read it. Use it. It will make a difference.

Watch out! Here come the SOLUTION GNUS

They're back! Just when you thought you were pushing back into the problem-focused savannah, our very own solution-gnus have come stampeding back to save the day! This month our readers have posed some absolutely fascinating questions for them. If you have something that's been puzzling you, or if you'd like the chance to mull over some curious SF questions in public, why not write to gnus@solution-news.co.uk. We're here to helk!

Dear Gnus, if I want to use solution focused therapy do I have to give up other approaches? And if I don't, will I get confused?

Dominic Bray gnu. He said:

Speaking from my practice rather than learned books, I would say "not necessarily" to both. Purists might say that it's like oil and water...SF and expert/diagnostic/norm-based approaches don't mix. I would say you need to be able to do both, sometimes with the same client/ patient. For example; in my setting, my patients sometimes really do want advice. They also often like to 'know' they're normal from someone they construe as having expertise (me, great hilarity now follows). In both instances, I always put the 'expert' bit of knowledge in an SF frame ie ask "...and how will we know when it's the right advice...?" and "are you the kind of person who likes to feel normal...?". In other words, the expert bit only goes in if its part of their preferred future to receive it. Oddly enough, if you think about it from the other end, refusing to speak from an expert position when asked is arguably not being solution-focused: suddenly you know better than the client/patient about what's good for them. And sometimes, it's all SF.

Will you get confused? You tell me how good you are at flexibility of thought already, and how much confidence you have you will get even better! In my opinion, it's always good to be able to monitor the 'fit' between your approach and the client/patient's. Occasionally, it's useful to make it explicit at least to yourself...eg I have changed chairs when I have to ask problem-enhancing questions like benefits forms. But if you can live the flexibility...things tend to work!

Dear Gnus, what do you do if an SF approach doesn't work?

Steve Freeman gnu. He said:

In short "Something else that does work".

Because solution focused approaches work so well it is easy to fall into the 'works every time' trap. By paying close attention to the client(s) we can see not only the way that SFA works but also the clues to when it does not.

There seem to be two distinct ways in which the approach does not work. Firstly, a specific question does not sit well with the client (or we were less than elegant in asking it!). In this case it seems best to own up to the fact that "That wasn't a very good question was it?" and go for something different. Secondly, the whole approach is wrong for this person at this time. This may be because the client simply wants an answer to a direct question or sees the worker as an expert. Whilst both of these customers can be approached from an SF perspective they may simply be shopping for something else. Whatever the reason it is time to respectfully change tack. Despite the efficacy of SF approaches we have to accept on some occasions that the customer is always right.

Dear Gnus, is it wrong to start talking to my kids in an SF way? I feel tempted and think it would work, but I don't want to start seeing them as clients.

Vicky Bliss gnu. She said:

Firstly, I like how thoughtful you are about the way in which you talk to your children. In the business of life, it is all too easy to stop thinking and start reacting when we go from work to home.

When at work, a therapist's job is principally to listen, clarify and work with a person to find a way to move forward. Work is an ideal place to be impartial, genuinely 'not-knowing' and adopt a 'one-down' position because we as therapists have only one role with the person.

At home, there will be times when this same competent SF worker will need to hack through the family jungle without apparent regard for the immediate needs of the toddler who is storing beans in his nose or the neighbourhood children who are jostling through the kitchen like a herd of dairy cattle. At these times, my thought is that an SF therapist could actually do him or herself a mischief by trying to impartially co-construct a way forward that satisfies everyone. Not, as you suggest, because it is wrong to think of family members as clients but because it would require ingestion of suspicious chemicals to do so.

However, in the calmer moments, when your children come to you in an orderly fashion (or as near to this as is possible) and you wish to listen to them without judgement in order to hear what it is that will make a difference for them and help them to move forward in a direction of their choosing, solution focused techniques are just the ticket. SF philosophy and techniques are not exclusive to people labelled 'therapists' and 'clients', they are for use between two experts who wish to work together towards a mutual aim. Use them whenever you can.

MORE FROM THE GNUS NEXT ISSUE...

MEMBER NEWS

This section is for members to let people know about what they've been up to or is happening for them, and for requests for help. If you have an announcement, please post it to: news@solution-news.co.uk.

Member Steve Freeman wanted let members know about his appointment to a 12 month secondment as Solution Focused Approaches Manager for Combined Healthcare NHS Trust in North Staffordshire. In a subsequent open meeting in late April a team of practitioners, managers, organisational development staff, psychologists and psychiatrists agreed to pursue the development of a range of solution focused activities on a trust wide basis. These included the continuation of a training programme and initiatives aimed changing the 'visitor experience'.

Member Vicky Bliss wanted to tell everyone about the Missing Link Support Service. "This is a fledgling service intended to provide solution focused support to people who are disabled by society. It is especially geared to helping people who do not 'fit' into mainstream statutory services. For example we work with people who have autism, Asperger Syndrome, learning disabilities, personality disorders, memory or attention problems and a wide range of carer, both paid and unpaid. The service is mainly offered by Vicky Bliss, Counselling Psychologist with critical support given by three survivors of mental health services; Geneieve Edmonds, Marina Whiteside and Emma Loughlin. Genny and Marina are just finishing the Carlise course in SFBT and Genny has started practical work as a therapist. Her Asperger's Syndrome gives her a nice head start in understanding people with autism. Marina is excelling herself in offering practical help for carers and in training staff in learning disability and mental health services. And Emma, with her life long experience of learning disabilities offers a comic, memorable picture of her experiences of statutory services to workshop and conference participants. More information can be found on our developing website www.missinglinksupportservice.co.uk and we welcome referrals, workshop / conference bookings and inquiries from anyone."

The Yorkshire Solution Focused Brief Therapy Group have two upcoming events. On 6th June, Judith Milner giving a one-day presentation on "Solution Focused Approaches and the Phenomenon of Violence" in Sheffield. The cost for the day will be £50. On 17th & 18th October 2005 in Bradford, Insoo Kim Berg will be hosting a two-day workshop looking at "solution Focused Therapy in Difficult Situations". The cost for the two days is £150. For more information on either of these events, please contact Greg Vinnicombe at greg@vinnic.fsnet.co.uk or on 0793 0879 784, or go to www.yorkshiresolutions.org.uk

NEXT ISSUE:

Conference special, including accreditation vote result, workshop summaries and independent member views!

Plus more letters, reviews, and those ever present gnus!