

# Solution News

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## Articles in this issue:

### **Solution Focused Front-line Services**

**John Wheeler** discusses his experience of a solution focused child protection service

### **SFT and Breast Cancer**

**Dominic Bray** gives his perspective on treating a patient with serious physical health problems

### **SFGP!**

**David Unwin** talks his use of an SF approach in his general medical practice

### **For Steve de Shazer**

A tribute

### **ESTEEM part one**

**Ian Johnsen** shares his conceptual model and solution focused training materials

### **The Professional Service Users**

**Per Ljungman** writes about a workshop he attended run by Missing Link Support Services

## Also in this issue:

### **Editorial**

### **Book Review**

### **Association News**

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

### **Solution Gnus**

All your questions about solution focused working answered

### **Member News**

Information on what our members are doing and plan to do



Hello all and welcome to our biggest issue yet! Since the last issue our readership has continued to grow, and we have gained some readers from South America (ola amigos!),

which means we now have readers on all six continents. More details on our distribution appear later in these pages. The growing international nature of our readership is reflected by the fact that we have writing from authors in Sweden and Australia this issue.

On a more sombre note the death of Steve de Shazer in September was a shock to many in the solution focused community, and our thoughts go out to his family and others who knew him well. There have been many fine obituaries written already (including one *The Guardian* national daily newspaper in the UK) and so in this issue we have included something a little different as a tribute, which I hope you will find interesting.

As I've said before, when *Solution News* was started all we had was a 'preferred future' that it would be great to have a friendly forum to share SF ideas in. What *Solution News* has become so far seems more like a miracle. But any bulletin is only as good as its contributions, and we urgently need more articles for next year's issues. We are happy to comment on drafts, and are hoping to move to a peer-review system in the next few months to give authors even more feedback.

The bulletin is, and will continue to be, completely freely available and distributable to anyone who finds it useful. So, for your new-year resolutions, please (1) write something for us, and share your solution focused ideas and experiences with others around the planet, and (2) tell others about *Solution News* and get them writing too!

All the best for 2006!

***Ian C. Smith - Editor, Solution News***

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# Solution Focused Front-line Services

## **John Wheeler** argues for adopting the solution focused model in child protection social work teams

**W**henever I've trained mixed groups of practitioners I've felt a twinge of excitement when I've found that the group includes practitioners from front-line services. I've not been too surprised when practitioners from secondary services see the potential usefulness of solution focused work. These are the services who often become involved when a need for therapeutic work has been identified, so there is already the beginnings of a platform to work collaboratively. Front-line services are another matter. For most people this is the first point of contact with services. And this is the first critical moment when the work either goes down a client-centred, goal-oriented, solution building route, or something else. My first published case example (Wheeler, 1995), came out of my growing awareness of how we as practitioners influence, by the questions we ask, the people we work with. And how we then make judgements about them based on what are often their reactions to us. An enormous work force of front-line practitioners is influencing the subsequent service involvement of vast numbers of people who come to them for help at times of crisis and vulnerability. I suspect that there is still scope for solution focused training to make a big difference. Prior to delivering a workshop at the

EBTA conference in Dublin, I imagined a triangular shaped diagram which might portray the spread of practitioners the public come into contact with. Down the pointy end are the specialist therapeutic practitioners who do highly skilled work, but who as a total group see a proportionately small percentage of the public. Down the other end are the front-line practitioners who see by far the biggest majority. Suppose all of these knew about the difference between asking clients for their ideas rather than telling them what to do: building on what's working rather than focusing on what's going wrong.

My main reason for writing this short article is to draw the attention of as many people as possible to a recently published article by myself and my colleague in Gateshead, Viv Hogg (Hogg & Wheeler 2004). For several years Viv and her team of child protection social workers have been living proof that solution focused practice can be successfully embedded in front-line services. The quality of their practice also manages to address all the qualms and niggles which typically arise when people doubt that solution focused work should even be attempted in such practice settings.

In 2004 I had a fascinating time attending workshops at Brief's conference on working with children and young people.



**John works as a social worker and family therapist in a Child and Adolescent Mental Health Service. He also delivers training to a wide range of practitioners, offers supervision and works with organisations on solution focused team building and change management. He can be contacted through [www.johnwheeler.co.uk](http://www.johnwheeler.co.uk)**

I was impressed by the evident growth of early intervention support teams using solution focused practice with families in crisis. Sadly, throughout the day, however, I heard a prevailing story about child protection social work colleagues. "It's a shame they are so negative", "They are so cynical and burnt out" "If only they would work with service users in the way we do". On numerous occasions I just had to say "Well its not like that in Gateshead". Thankfully others joined me at times, revealing that solution focused child protection Social Workers aren't just an endangered species in Gateshead, but can also be found elsewhere.

In 2004 Viv, I, and two members of her team, Sharon and Haley, presented a workshop at the pre-EBTA conference event in Amsterdam. The event was attended by a large number of people from across Holland, all with an interest in child protection. People were clearly impressed by the practice shared by Sharon and Haley. Interestingly one participant then asked how big the caseloads were in Viv's team, commenting that she too would like to be able to offer the same quality of work but had too many clients. A reply of "about twenty" came as quite a surprise to many in the room. As the workshop ended, Andrew Turnell who was watching the presentation was speaking to a Dutch child protection social worker. When he asked her what she thought of the presentation she said she was very impressed, but of course wouldn't be able to use the approach herself as she had too large a caseload. Suspecting that she had not heard the detail of the earlier question and response he asked how large her caseload was. "Eight" she replied. "Did you hear how big the caseloads are in Viv's team?" he asked, delighting in what was coming next. "No", she replied. So he told her.

**"Workers using solution focused practice are rarely off sick, stay in front-line practice much longer than the average and are probably the jolliest bunch of people you could hope to meet"**

For many it still seems hard to believe that solution focused practice could be useful in front-line services.

"Front-line practitioners are too busy, and would need to have protected time to work with their clients in this way."

Well, no. In Gateshead we've found that workers with caseloads which are typical for their setting can use solution focused thinking and tools on a routine basis in all of their dealings with clients. In fact the versatility of the approach lends itself very well to the variety of ways workers engage with clients.

"Front-line practitioners have performance targets to reach so can't afford to be doing something which might take more time"

Well, in Gateshead we've found that using solution focused practice has not spoilt the performance targets. In fact practitioners using a solution focused approach find that it actually helps them to reach their targets because they are engaging with families

more quickly and the clients are coming up with most of the ideas.

"It would be dangerous to use solution focused practice in services which deal with high levels of risk"

Well, in Gateshead we've found that solution focused tools have made it easier to assess risk, and when children have needed to live elsewhere the tools have quickly generated the information the worker needed to know to decide to arrange this.

"Front-line services are dogged with burn-out, high sickness rates and high staff turnover."

Well, in Gateshead we've found that the practitioners using solution focused practice thrive on the work, are rarely off sick, stay in front-line practice much longer than the average and are probably the jolliest bunch of people you could hope to meet.

So there you go. Robust answers to most of the objections which are usually raised when people wonder whether solution focused practice can be done in front-line services. If you don't believe me, read the article.

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# REVIEWING BOOKS

**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, please contact [books@solution-news.co.uk](mailto:books@solution-news.co.uk).**

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- Team Coaching with the Solution Circle by Daniel Meier
- Solution Focused Stress Counselling by Bill O'Connell
- Handbook of Solution-Focused Therapy. Edited by Bill O'Connell and Stephen Palmer

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European Brief Therapy Association web site is at [www.ebta.nu](http://www.ebta.nu)

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

SOLUTIONS-L is an international discussion list for those using a solution focused approach with organisations. It's at: <http://www.solworld.org/index.cfm?id=5>

The Brief Family Therapy Center (Milwaukee, US) website is at [www.brief-therapy.org](http://www.brief-therapy.org)

# A Solution Focused Intervention with a Nurse with Breast Cancer (part one)

In the first of a two-part article, *Dominic Bray* describes a solution focused intervention with a client in his service. In the second part (next issue), the client and her partner will give their perspective on the work completed.



**Dominic works as a Clinical Psychologist in general hospitals with people with a variety of conditions including cancer (oncology and palliative care), renal failure, chronic pain, ME and fibromyalgia. He also does quite a lot of training and supervision for medical and non-medical staff. He's also the UKASFP Chair, 2005-2006.**

## Introduction

A remarkable feature of solution focused (SF) approaches is the de-emphasis on a diagnostic/problem formulation/treatment/advice-giving role for the therapist. This has the paradoxical effect that, whilst SF approaches are relatively simple to describe, given the problem-focused training of most health care professionals, they can be surprisingly difficult to apply. It is also frequently the case that it is yet more difficult to conceive of them actually bringing about any noticeable change for the better in a patient's existence!

With respect to academic heritage, SF approaches have more in common with hermeneutic ideas of exploring individuals' experiences and understanding of wellness than bio-psycho-social models - for fuller discussion see Crossley (2000). Despite an increasing range of uses in mental health-type and organisational settings, and explicit citation in the UK Department of Health's NICE Guidelines for Supportive and Palliative Care (2004) there is little reference in the literature to their use in physical health settings. Exceptions to this include the partial use of a SF approach with a family affected

by metastatic lung cancer (Neilson-Clayton and Brownlee, 2002) and one account of an SF intervention with a patient an unnamed cancer in Johnson & Webster (2002). There are also strong elements of SF thinking in the accounts of a group of palliative care patients in the work of Staton and colleagues (2001). As a contribution to this field, the following is offered as an example of how the use of SF principles with one particular patient appeared to make a significant difference to the quality of her existence.

## The Intervention

Linda, who by coincidence was a Nurse in the same hospital as the author, was referred as an inpatient from an Oncology Ward because she had become withdrawn, facing away from social interaction with little engagement in any daily activity. During the first encounter, at the bedside using SF principles, the author enquired of Linda in the course of conversation whether she wished to stay in this state or to find some way of "facing the world again." The latter being the case, it also then emerged that normally when faced with difficulty or even time on her hands, it would be

## SF Intervention with a Nurse with Breast Cancer by Dominic Bray

Linda's normal practice to read magazines and watch some television. She also valued being able to go out and telling her husband what to do (!) These were all steps towards Linda regaining her life which then not only served as 'markers' to her recovery but also stepping stones which gave her encouragement. She also decided she would like to be able to face her work colleagues who literally worked two floors below her hospital bed.

A week later, Linda seen as an outpatient was once again facing the world and, in fact, had actually gone downstairs to see her colleagues. Further, having been discharged a few days' earlier, she had noticed that she was beginning once again to tell her children and husband what to do.

In SF terms, all these were exceptions to the problem (her problem being an ability to deal with the world). A further hint that she was coping better came from her recollection of a conversation with her husband, Gary, who had apparently (when they were on an outing) asked that they forget about the cancer for half an hour, a sign, she later agreed, that he perceived her as being stronger. On the other hand, Linda had also had two bad days when physical symptoms had been particularly adverse. Again using SF principles, having acknowledged the difficult times, full attention was also given to the times when physical symptoms had been better, in keeping with the SF principle of 'noticing the doughnut rather than the hole'. i.e. selective attention to signs of success rather than failure. Linda also described how she was "slowly coming out of my bubble", i.e. being able to be more optimistic about the future rather than feeling trapped in a bubble of cancer. Importantly, attention was also given to what the next steps might look like towards her preferred future, i.e. 'getting herself back again', and these included driving once again with its accompanying independence.

**"SF principles have the potential to make a significant contribution to psycho-oncology and psycho-social help in physical health"**

At the next appointment, approximately two weeks later, Linda explained that she had experienced a number of recent successes but on the other hand was quite perturbed at the thought of a recurrence of cancer; an example of the 'Damocles Syndrome', (Koocher and O'Malley, 1981). It emerged that Linda had been getting out in her car, doing more housework, organising the household, going out, keeping up her treatment, coping with a bereavement and even confronting friends and acquaintances who had offered easy platitudes which would otherwise have rankled, if not challenged. Once again, using SF principles, Linda and the author defined the 'Damocles' scenario in terms of learning to live with uncertainty.

The author therefore enquired of Linda what time in the past she had succeeded in doing this and it was quickly established that she had been in a fairly serious car accident, entirely not of her own making and quite unpredictable. Importantly, she had learned to live with the 'post-traumatic' loss of the certainty of her invulnerability and had been able gradually to drive again, despite some (and still continuing) anxiety.

Having then established a competence on Linda's part to deal with a not-too-dissimilar situation, Linda was then asked to contemplate "how did you do that?" and was invited to "do more of it", well-used SF axioms.

A further three weeks later, Linda reported that she had been to a society ball, had been out a lot in her car and achieved various other household triumphs. This progress was achieved despite the setback of knowing someone else she had met in Oncology Outpatients who had died with a similar profile to hers. She was beginning to conceive of feeling better, as if "the bubble now has holes in it." At that appointment, it also emerged that Linda's daughter, Sarah, was not sleeping very well. As with many cancer patients, the fall-out from cancer and its treatment had not stopped with Linda herself.

## SF Intervention with a Nurse with Breast Cancer by Dominic Bray

At the next appointment, a further three weeks later (in line with chemotherapy appointments), Sarah and Linda's husband, Gary, explained that Sarah felt a sense of distance from her mother. In subsequent discussion with Linda that day, it emerged that Linda too had felt this and she was able to describe, again using the idea of the preferred future, the kind of relationship she would love to have with her daughter. This then led to a discussion as to how this might happen. For example, a key element which emerged was making sure she had good time with Sarah when she wasn't tired and that was most likely to happen mid-morning.

At the next appointment, Linda was once again able to report further improvement and, as a positive sign of this, she had noticed how she had talked to yet another poorly person of similar clinical picture in the waiting room and although she had initially been set back by this, had recovered more quickly than before. Further, she had been able to support her husband Gary when he had been upset by the distressing news of a next-door child herself contracting cancer. As that was the final day for her chemotherapy, at that point Linda decided that she would like to finish her and her family's appointments with me and they stopped at that point.

A further six weeks later, another appointment was arranged because Linda had felt a sense of isolation at the end of her active treatment (see Holland *et al*, 1979 for references to end of treatment issues). Linda also explained that she had a sense of being emotionally left more to her own devices by people and a sense of her role as housewife and mother being taken more 'for granted'. On the 'up side', she had done a lot of work on her relationship with daughter and was listening better to her.

We therefore talked about what the next steps would be in her life, i.e. would it be as a full-time housewife or would she also like a role outside of home? On this account, we identified that she had enjoyed her experiences in the Chemotherapy Suite where she had been able to offer emotional

support to other patients and this had given her a sense of fulfilment as nursing had done before. At the end of the appointment, although a further appointment was not scheduled, Linda promised to report back. This she did four weeks later and reported that she had had a wonderful weekend away with husband, and she had also had some good news about bone scan results which had helped her mood. At the time of writing, Linda remains on the author's 'books' and understands that she can have another appointment whenever she might wish to.

### Conclusion

The application of SF principles appears to have been helpful to Linda. Further uses of SF principles in oncology include medical decision-making, conversations with palliative care patients and staff support (accounts of which will follow at a later date).

In closing, the author would like to rehearse one dictum from Confucius and one from a client of a solution focused colleague. Confucius apparently once said "The gentleman helps others to realise what is good in them; he does not help them to realise what is bad in them. The small man does the opposite." The client, on her part, offered this definition "solution focused therapy: a temporary treatment which concentrates on answers." These two descriptions summarise solution focused therapy well for me. In no way would the author argue that solution focused principles are a cure-all for all situations or that they negate progress made by bio-psycho-social approaches. However, it is also arguably the case that they have the potential to make a significant contribution to the field of psycho-oncology and psycho-social help in physical health in general.

I would welcome responses to all these ideas as applied to oncology and dialogue with those interested in taking these ideas further.

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## BOOK REVIEW

**Solution-Focused Therapy (Second Edition) By Bill O'Connell (Brief Therapies Series) Sage (2005). Price £17.99.  
Review by Maggie H. Pickering, Counsellor and Trainer.**

Bill's comprehensive book has been completely modified and readers of the original would be well advised to examine this new edition, especially for the new revised chapters on solution focused supervision, reflecting teams, and integrating solution focused therapy into existing practice.

The book is structured pragmatically, starting with the foundations of brief therapy, progressing to chapters on the solution focused model, and then moving to a detailed explanation of the first session, second session, and beyond. Throughout Bill keeps focused on solutions in a professional and sensitive manner.

My view is that this book is essential reading for trainees and also useful for busy, experienced, front-line health professionals. The main reason for this broad group of readership is the usefulness of the thought-provoking text. It makes plain language an art form and the writing firmly places the client and their skills in a central position, with theory and therapist in a 'position down' (as described in the theory of SFT).

The style of writing is interactive in that the reader is encouraged to reflect after each chapter on the practice points that have been highlighted. These points will be popular with

both trainees and professionals, and also those trainers looking for that 'something extra' to make sessions more potent. These gems address the essence of solution focused therapy and remind practitioners to stay firmly on track and trust in the model.

Examples of these 'reflecting points' include:

- "Consider how it would affect your work if you believed that 'truth was not there to be discovered, but to be invented.'"
- "It can be helpful to check with clients what they don't want to change."
- "Keep hopeful, especially when the client isn't"

This is an eminently practical book that identifies and explains the main skills needed to use solution focused therapy in most health settings. It demonstrates beautifully, with very carefully selected words the manner of implementing this approach by co-creating a respectful and humble alliance to achieve the changes the client requires. Throughout Bill focuses on describing good SF practice and how to put it into action by adopting a 'moderate' solution focused philosophy that centres on believing in and giving credit to the client.

# SFGP! Why A Solution Focused Approach Is Brilliant In Primary Care

**David Unwin** talks about his fascinating work bringing a solution focused approach to his general medical practice.



**David Unwin has been a GP partner for 20 years and a GP trainer for 14. He is involved in GP appraisal and is promoting a solution focused approach in his local hospice.**

Attending the UKASFP annual conference in Preston last June I was surprised to find I was the only General Medical Practitioner (GP). Delegates I spoke to said they were having difficulty getting their GPs to take an interest in the SF approach. This is a shame as it has so much to offer and I thought it may be helpful for some of you to have a note of why I (as a ? fairly normal GP) find it so exciting.

Twenty years ago, as a very keen GP Registrar, I began to worry how it would be possible for me to take on and solve all the many problems of my patients, and I felt the weight of them get slowly greater day by day. How could I cope for years on end? Then I reasoned that Social Workers had possibly even a worse burden than mine, so I resolved to look around for an old Social Worker who still seemed optimistic and cheerful. When I found him I asked him what his secret was and held my breath. Patiently he explained: when taking a history I should find out what little things the client had already done to cope so far and explore this as a route to the solution, rather than feeling I alone had to instantly "cure" all problems. Later I added some cognitive bits and pieces to this and muddled along. Then, when I encountered

solution focused therapy its wonderful possibilities leapt out at me! Anyway, enough of the preamble, back to why a solution focused approach is brilliant and fabulous in primary care.

## **1. Your Waiting Room Will Be Full of Heroes not Heartsinks**

All GPs struggle with the hopeless helpless who come in week after week ('why?' we wonder, 'why?'). The fact is we have trained them to come in and moan, it's what we and they expect. "What's the problem?" we ask – is it the panic attacks, tinglings, man next door or the dog again? And off we go. The only way to get my attention is to go on about your problems! Then I, after a while, feel acopic because of course I can't solve any of these problems, and solving is a GP thing, it's what we are trained to do. I become irritable and short-tempered and wonder if Prozac may keep them away a bit longer? However, try and turn this around. Compliment your patient on small successes and being a survivor. Practice some active listening, and the patients will think that you are wonderful, astute, observant, maybe even caring! It's a miracle, the start of some mutual respect - and you will find that they are heroes after all.

A few years ago I was allocated a patient (this is how the Primary Care Trust finds a GP for 'difficult' cases), and he was so demanding and aggressive that he had been round every practice in the town, and had even changed his name - so we accepted him without realising he had been thrown off our list before. However, this time I was ready with my new approach. "That must have been really hard" I cooed, "you're obviously a tough cookie, what is it that has helped you cope all these years?" Shocked, he looked at me as if I'd gone mad. He had come expecting a fight and I wasn't playing the game. Usually he banged the table and complained that no-one cared and would have asked "what are you going to do about it?" This usually took so long he always had a double appointment. Now he is always polite, and as he leaves he thanks me as he shakes my hand, saying I'm a good lad! Who says miracles don't happen?

## 2 Aspects of This Approach Can Be Very Brief and Fitted into an Ordinary Patient Contact by Nurse or GP

GPs tend to feel that anything with 'therapy' in the title must take more than 45 minutes. In fact, I am quicker than many Doctors and run seven-and-a-half minute appointments and there is still time in this for positive feedback, scaling etc. Even an average patient consults four times per year, so over the years it's surprising what can be achieved. Gradually patients learn that I am interested in their successes and strengths, and gradually I have learned to look out for what is positive within their stories. All this also applies to busy Practice Nurses, District Nurses etc, particularly those managing chronic diseases, as these clinics can become real moaning shops, and yet could offer a real opportunity for a solution focused approach, becoming happier places to work. Noting exceptions is another component of

the approach which can be used by anyone dealing with chronic pain, depression, or anxiety. Yesterday I saw a lady almost rigid with anxiety, having many panic attacks each day. I asked if there had been times over the past week when she had felt more in control, and then how it felt, and what she was doing at the time. Before she left we agreed some homework: she would look out for some better times over the coming week and make a few notes. These could form the basis of a more formal cognitive approach or the solution focused theme could be developed further with her.

This brevity and fitting some aspects of the approach into ordinary work means it may cost very little - perhaps just a few training sessions. As GPs are self employed, it is vital to understand that extra Practice costs mean less for the Doctor to take home. People wishing to bring about change in General Practice often ignore this and wonder why nothing changes!

Of course some of the brevity of this form of therapy is a spin off of not concerning ourselves with the details of 'the problem'.

Many of us are familiar with the elderly lady who comes in with "Well I don't know where to begin- it all began in 1982 with a cheese sandwich, or was it egg? I know it was a Tuesday because Brenda (she's my daughter by my first husband) always came to visit then on account of the buses...". As she would go on and on, in numbing, stultifying detail, eventually I would lose the will to live, wondering if she might just run out of breath? One of the reasons that histories that begin like this are so trying to a GP is that we intuitively feel it's a waste of time - and now I know why. It's because masses of history may have very little to do with the solutions we need to look at. How much better to cut in with "What are you hoping I can do for you today?", or to talk about the problem just as- 'it', along the lines of 'it would be helpful if I could get an idea of how bad it is today, on a scale of one to ten. The details of what constitute 'it' may never have to be gone into.

**"The fact is,  
we have trained  
our patients  
to come to us  
and moan"**

### 3 At Least "Do No Harm"

As a young GP I would dabble in a bit of psychology as (I thought to myself) at least it wouldn't do any harm! I failed to see that rummaging in patients' psyches could be a nasty pernicious thing, e.g. "So you see Mrs Smith, now that we have discussed your miserable childhood, I think we can see why its no surprise that you are unable to cope or develop any useful relationships". How does that leave the patient? With a feeling it was inevitable they would turn out badly, of course! There is a lot of this pseudo-psychology around these days, and quite a lot of it is in primary care. It can be particularly dangerous in depressed patients who may pounce on any evidence that confirms their worthlessness. Again this is where a solution focused approach really scores.

### 4 Appraisals Training and Mentoring

All GPs and their staff have to have a yearly appraisal. This is an opportunity to do a lot of good things for staff, such as giving positive feedback, and finding out more about them and where they hope to be in the future. There are of course a lot of standard forms for staff to fill out, but unfortunately the replies they produce often turn out to be pretty standard too. Instead, try asking what they feel they have done well, followed by as many 'what elses' as you can stand. Then validate the reply with "Yes I've noticed that you're very ...", and make the positive observation as specific and accurate as possible. It's very motivating when special efforts are noticed. Most of us are too shy to 'blow our own trumpets'. In fact, GPs in training always want to talk about their weaknesses and have to be forced to reflect on strengths. Even then, they tend to say "I know I did well in that way, but I just wish I could ...".

Sometimes staff are unhappy at work and it can be difficult to find out what they want to change. In such situations the miracle question can be really useful. Others are

clearer about changes they would like to make, and so in these situations scaling can be used.

Sometimes staff mention changes they would like to make and you wonder if they really do want to take that diploma or are they just saying it as a way to impress? In such circumstances it's useful to ask "what would be different if you did that ,and how would it feel?"

### 5 Communicating with GPs

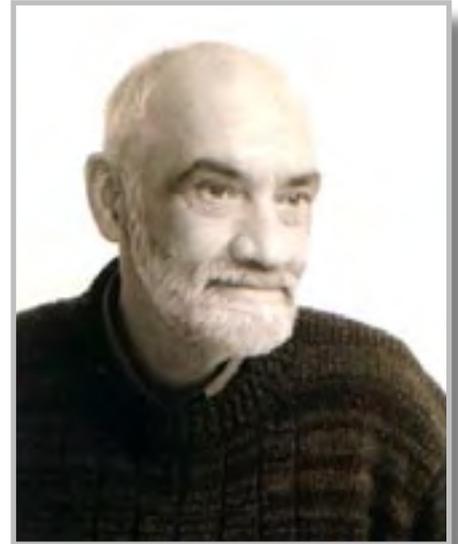
Finally, just a few points on the best way to communicate with family doctors. Until a few years ago I thought GPs were normal and the same as other people, but then all my friends were GPs . Marrying a Clinical Psychologist I was surprised how different they were: more cautious and diffident in their opinions, and when making a point they took ages over it. Then I began to wonder how being a GP had changed me and my GP friends? For decades we see 30-40 patients per day, and we have less than 10 minutes to 'solve' whatever they come with for them. This leads to us becoming rather time pressured, and anyone wanting to get our attention needs to come to the point fast or risk being written off as wishy-washy. So, when dealing with a GP, state what you want right at the beginning, otherwise he can lose patience as he tries to guess. It's also more efficient if the conversation is experienced in the context of your 'best hopes'.

If you've borne with me to the bitter end, then thank-you. Good-luck with with your GPing or in talking to GPs!

# For Steve de Shazer

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On 11th September 2005 Steve de Shazer passed away, sending a ripple of shock through the international solution focused community. In the days that followed, the email discussion lists were filled with posts from those who wanted to pay tribute to him. These messages told stories about a man who had influenced not just the practice but also the lives of those who had met him and also those who had made themselves familiar with his work. There were fond memories of personal encounters and lessons learned about practice in these messages. Most of all they were inspiring and thought-provoking to read, and in themselves said a lot about the legacy that Steve de Shazer has left.



What follows is a montage of extracts from some messages and thoughts copied to me by subscribers to the SFT-L list, whose authors have kindly given permission for their writing to be reproduced here. Thanks to all who consented, and I hope we haven't mutilated your words too badly. We haven't cited individual contributors here, but if you find reading these extracts as valuable as I did, you may wish to visit the SFT-L archives for September 2005 at <http://maelstrom.stjohns.edu/archives/sft-l.html> to review the postings in full. Many thanks are due as ever to Harry Korman for hosting the SFT-L list, and for his astute, curious questions to list members. Thanks also to the Brief Family Therapy Centre for allowing us to use the picture above.

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"Years ago, I was driving home listening to a radio interview. I was so gripped by what the speaker had to say that I pulled over to the side of the road to hear it in full instead of turning up to my destination, something that hasn't happened before or since. It was Steve. I got on the trail. What a difference it has made to my work and outlook!"

"Thank-you Steve for being so determined to sort through everything that was supposed to work and leaving us with such a clear definition of what usually does"

"Through all the years I'd never seen Steve in person, but when I did his ideas came alive before me in a quiet, humble and deeply passionate way that I will carry with me. He had eyes and ears that noticed everything, and a voice that he used sparingly and with unpredictable consideration. Thank you for: reminding us that it is about what works for the client; the irreverent humour; illuminating the difference that unfolds when we collaborate with the person, and for allowing yourself to be an inspiration, a frustration and a joy to others. I look forward to continuing to share what you shared with us with those who have yet to discover your legacy."

"I've been listening to a lot of Miles Davis, thinking about Steve and his awesome use of silence. I recall being told by a musician that they hear the silence into which they play their notes, and it dawned on me that Steve (who was a musician) had this acuity. I suspect silence wasn't an absence for him. It was a way of communicating, probably a music all of its own."

## For Steve de Shazer

"I remember the warmth with which he told of his father's belief that the universe contains only a finite number of words and that we must therefore be very careful how we use them."

"I hope that his voice will stay with me and with the many others whom he influenced. I will miss his smile and his advice about beer."

"I feel his tap on my shoulder whenever I get stuck and stop building solutions with my clients"

"Steve embodied a very profound kind of faith; I asked him once if he assumed that the client has the resources they need to solve their problems. He answered, 'It isn't an assumption, it's absolute fact.'"

"I first met Steve at the tip of Africa in the mid to late 80s - not in person but through his words. At first the staff at my University asked why I was ordering these strange books (Patterns, Clues and Keys) for our library - and then they decided they might need to buy some duplicate sets because people from all kinds of departments (computer science, engineering and medicine) seemed so keen to read them that the psychology masters students couldn't get hold of them!"

"When we interviewed Steve, we didn't record on the transcript that we were simultaneously tasting and scoring on a 0 to 10 scale various beers brewed to English medieval recipes - in fact, it was probably this that allowed us the chance to talk to Steve, with a tape recorder running, for a whole afternoon."

"A close colleague complained that "the problem with Steve is he doesn't 'role reverse' with anyone". I said "Yes, I know, and isn't that fantastic?" I get heartily sick of so many helping professionals trying to do other people's thinking, feeling, experiencing for them."

"I treasure the brief time I spent with him and Insoo while he cooked dinner for us in his back yard. We are all better because of what he taught us about the human spirit"

"SdeS will be greatly missed. His gruff compassion, his zeal for brevity in therapy and his love for his 'child' - SFBT will be only a fraction of his legacy."

"You can see it in the tapes of him working, too. Steve doesn't seem to say or do much, but the clients find such amazing things within themselves. They feel listened to, like someone really believes they are worth listening to, because something really interesting is about to be revealed. And often, it is."

"He said "When you ask the Miracle Question, shut up and wait, it's their turn." I suppose that could be equated to a sales seminar I attended where they taught us to make your pitch and then be quiet - the first one to speak loses that battle."

"I will always remember the small moments: taking a group of us for Korean food in New York; sharing jazz and schnapps; the excitement in his eyes when someone 'got it'; the passion for Dr. Who, whose solutions to problems relied on luck as much as deduction. 'Shit happens', he used to say, to explain the 'bad stuff'. No blame, ever. He created a language

## For Steve de Shazer

and a practice for therapy to never again blame the client, however subtly. I am deeply honoured to have known and learned from him."

"I once said to him, after watching him interview a client, "It seems like you aren't afraid to look like you are asking a stupid question". He said, "It's not about not *looking* stupid -- I'm not afraid to *be* stupid." By which he meant it wasn't a strategy. He was really, truly okay with asking a question to which he had no idea what the answer was going to be. He didn't ask the questions to push an agenda, or to show how smart he was. He asked because there was something he knew he didn't know the answer to, and he was curious to find out what it was."

"I grew in his presence and under the influence of his intellect and influence. I always knew I wanted to match his rigour in what I did in my work. What was it like to watch him work? It seemed to me that Steve was often 'hearing the inaudible' when he was doing therapy."

"I remember the silent, puzzled look that greeted some of the more meaningless questions about "what do you do if.. ?" This made me think about many of the muddles we get ourselves into when we favour hypothesis and categorisation over observation and listening."

"When I had the pleasure of seeing him working in September 2005, I admired his benign impatience. He said (I paraphrase) "If you can get results without asking all the questions good; I don't give a shit". So thank-you Steve for giving my practice a big kick up the backside. I am sorry in a very selfish way that you won't be around to keep kicking me."

*"September takes Steve*

The Oak has fallen  
Silver and grey leaves gone black.  
His roaming eyes? No more.  
His eruptions? Quiet. In the dark. still. waiting for the team.

He gave us miracles & scales  
And a chance to roll the dice with the gods.  
But more...  
a thundering heartbeat for the small & slow.

We never told him  
That we loved him for what he gave us.  
But we did.  
Thank you Steve,  
Thank you for everything."

**"We are the first generation of therapists to carry on Steve's memory. As I walk my own way, I recall how Steve invited me to walk in my own direction... and how he helped us follow his."**

# ASSOCIATION NEWS

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

The *UKASFP* general committee have been really busy since the conference. Paul Hanton provides an update of their work:

The committee met in early November and discussed a number of issues (full minutes available on web-site and SmartGroups). Briefly:

**Solution News:** The outstanding success of the online journal was recognised. Thanks once again to Ian and Marcia.

**Solution Focused Trainers Network:** Carole Waskett and Paul Hanton were preparing for the trainers' network meeting on 10/12/05. An invitation had also been added to the SFT international list.

**Accreditation:** it was felt that there were difficulties with Option 3 as voted for by the membership. This option would be very expensive and entail the Association policing members. We may have made a mistake in offering this option to members when we are not in a position to make it a reality. However, the committee does support members' desire for accreditation.

**Web-site:** The committee wanted to express their thanks to Mark Fletcher, who designed and launched the association's first site.

A tender for the new site has been developed by Paul Hanton & Barry White and is available from Barry. Details are on the current *UKASFP* web-site.

**Treasurer:** Beth Billington has agreed to become treasurer and has been co-opted onto the committee, to be ratified by members at the next AGM. Finances are healthy and the association's tax affairs are now in the hands of an accountant.

**National Development Officer:** Steve described his activities to date, and the committee felt his progress was excellent, given his time availability.

**Local Networks:** Carole had contacted all members who had volunteered to co-ordinate local networks, inviting them to contact her or any committee member if we could assist in any way.

**2006 Conference:** This is now being organised by only two people. Committee members would all offer their help, and hoped that other members could do so too.

**Roles and expectations:** Paul has drawn up terms of reference for the committee and structure of the association (available on the web-site). Comments from members are welcome.

The conference organising committee (often referred to as 'the hardest working group in the *UKASFP*') have also been trying to crack on with preparation for our third one-day conference on 16th June 2006. Janine Ross reports:

Unfortunately there's not much to say yet. A call for workshops proposals was issued via the internet discussion groups, and we've had some good responses to that. The organising committee were due to meet a few weeks ago, but were prevented from doing so due to adverse weather conditions. We will be meeting in January and will keep everyone posted as to out progress.



The *UKASFP* committees are always looking for feedback from members, and for help with organising things and promoting SF practice. Please feel free to email members of the general or conference organising committees directly or via the smartgroup discussion list with your thoughts, comments, or suggestions.

# ESTEEM: A Solution Focused Training Model (part one)

In the first of two parts, *Ian Johnsen* shares a conceptual model and some materials he uses when training teachers in solution focused working. This issue: E, S and T.

## ESTEEM: A Conceptual Model for Strengths Based and Solution Focused Question Techniques

A process involving:

**E**stablishing the context for conversation

**S**caling

**T**easing out a description of what is already working

**E**xploring the development of skills & know- how

**E**xploring experience of greater success &

**M**oving to identify the next realistic step

### Introductory Note:

This conceptual model, ESTEEM, is a rough guide to the process and the question types of strengths based and solution focused work as I understand it at this point in time. It is by no means thorough or all-encompassing; there are many other sorts of ways to ask these types of questions and other question types that are not covered that are also part of working in a strengths and solution focused way.

While it makes sense to 'establish the context' of your

conversation and relationship early and to round up a conversation by moving to identify the next realistic step or task, in practice the type of question asked depends on the client's answers. It is common to move between the types of questions with the flow of the conversation and to repeat the parts of process sketched out below over and over.

The questions are numbered so that in discussion it is easier to identifying the different examples and types - this is a training tool to rather than a coherent introduction to the application and issues of working in strengths and solution focused way.

The questions presented here are of course not original and in my understanding commonly used by the brief solution focused practitioners everywhere.

I have been particularly influenced by Michael Durrant at the Brief Therapy Institute of Sydney, by many other Sydney-side therapists and by a visiting Harry Korman.

### Establishing the context:

In this part of the process your aim is to get a picture of what the client hopes for as a result of the 'relationship', 'interaction'



**Ian is a Sydney based brief solution focused Counselling Psychologist. He works in a large boys high school, in child protection (as a family and adolescent caseworker), privately and with the Brief Therapy Institute of Sydney. Any comments to emailian@ihug.com.au**

or 'conversation' with you and what that might mean in practical, observable terms next week/ next year.../ or when your service is no longer useful or involved. When you ask these questions try to get as much detail as you can. They are difficult questions so go slowly and give clients plenty of time to respond. Be at your curious and respectful best and resist the temptation to give or suggest answers.

Some examples of the types of questions are:

- Q1. What are your best hopes for how our talking together will make a difference?
- Q2. What do you suppose will be the most useful thing for you / for us to focus on in our talking together?
- Q3. If our talking together is really useful, how will you know, how do you think that will make a difference for you?
- Q4. What will you notice, say next week at ... that will tell you our conversation and the ideas shared here were really worthwhile or useful?
- Q5. Who else do you suppose will notice and what will they notice?
- Q6. How will you know that they notice?

These sorts of questions at the start of a 'relationship' invite a degree of ownership in the process of reaching the 'client' or the 'casework' goals.

At the start of each conversation these questions signal a caseworker's belief in a client's ability to identify what is important to them and to take charge in their life.

They encourage a client to focus on a future context, one in which the efforts of both themselves and caseworker will make a difference for them.

They clarify for both the client and the caseworker the best and or the specific hopes for each conversation.<sup>1</sup>

### Some Notes about different relationships and establishing context

**When working with Other Agencies:** it may also be useful to ask these types of questions. For example; how do you see our working together will make a difference for this client? As we are more successful in our joint work, how will we tell and what will be happening from (XXXX) point of view ... etc.

### When working with relationships that involve Statutory Authority:

Paraphrased from Korman and Soderquist (1993) 'Talk about a miracle' (www.sikt.nu):

Depending on your role as a caseworker your responsibility for the lives of your clients varies between two extremes.

At a minimum your responsibility is only to try to respond to the clients as nicely as possible and to be as useful as possible.

In this case what happens outside the conversation is nothing to do with you and you have no accountability. A purely 'therapeutic' relationship where no duty of care is involved might be an example.

On the other hand you may have a 'State Officer' function. In this case it is going to be important to know 'how things really are'. You may have to establish, for example, "Are these parents really abusing drugs so much that they can't take care of their children?"

In many cases your responsibility will fall somewhere between these two extremes. When you are establishing the context or your 'relationship' it is important to clarify your context and your responsibility to the client.

To see working with people as a co-operative process, to actively engage a client in casework goal setting and to be 'strengths and solution focused' does not mean being stupid.<sup>2</sup>

See page 29 in Korman and Soderquist (1993) for examples.

## ***When our working relationships change for other reasons:***

It is not just in 'wearing different hats' that attention to a redefinition or re-establishing of context is useful. When working with more than one person, in meeting significant others for a first time, with multiple contexts, multiple goals, when conversations shift or stall or information does not seem to fit, we need to re-check that the context of our working together is clearly established. Are we still listening to what our client(s) want? Are we absolutely clear about the process of working toward this? And are our own roles and responsibility equally clear?

## **Scaling**

The scale is a heuristic tool and visual aid that is very useful in talking about the process of change and development.

Scaling questions are useful in helping to identify the extent to which things are already working and to then clarify the next small, realistic and achievable step toward the client's preferred future or goal.

They are useful in making abstract things more concrete and break 'black and white', and 'either / or' type thinking.

In these questions 10 generally represents a desired outcome or satisfactory resolution of a problem or difficulty <sup>3</sup> and 0 generally represents an earlier point in time or less successful or desirable experience.

Some examples of the types of questions are:

- Q7. On a scale from 0 to 10 where 10 is, let's say ... you are 100% confident, and 0 is not a hope in hell, zero confidence – how confident are you now?
- Q8. What gives you that level of confidence? Why 40% and not just 10%? What is it that already makes you somewhat confident?
- Q9. On a scale from 0 to 10 where 10 is you have achieved what you hoped for in our working together and 0 being the time you first decided to work toward this, where are you now?

There are many different ways to ask scaling questions: just drawing a scale; drawing stepping stones or pathways; using percentages; using staircases or objects to measure difference between points, or using your hands to signal the end points of a scale and marking some points along it.

There are also many different ways to use scaling questions: scale toward a goal; scale hope; scale confidence; scale willingness; scale coping; scale miracles; ...

It is important to remember, however, that scaling questions are really only useful to the extent that the scales are then explored with further questions.

These further questions are those that yield the descriptions that build a picture of what, when, where, and how, change has and / or will happen.

## **Teasing out a description of what the client is already doing that tells them that they are at the point they indicated on the scale.**

These sorts of questions help the client and worker to identify what is already working.

Some examples of the types of questions are:

- Q10. What tells you, that you are at \_\_\_\_ (number) and not at 0?
- Q11. Tell me more about how you are thinking and what you are doing, at this point, that is working for you?
- Q12. If we were to video-tape all the things you do, that tell you that you are at that point, what would we see on that tape?
- Q13. What else?
- Q14. When and where does this happen?
- Q15. How does it happen?
- Q16. What difference does it make?
- Q17. Who notices?

These questions are useful because they draw out the detail of the client's resources (family, networks, habits) or competencies (skills, attitudes, particular strengths and individual / intrapersonal qualities).

They can often be used in a circular fashion with more and more description being elicited. Beware however of verbally bombarding the client, which is especially likely to happen if things appear to be going slowly. Harry's rule is:

"If things appear to be going slowly, slow down" (Harry Korman).

They provide a pathway to explore further the client's know-how and to ask about times of even a little more success.

Many clients answer these questions by talking about what is NOT working rather than what is. That is they tell you why they are not at 10 rather than why they are not at 0. In this case listen respectfully and without building on the list or litany of complaints, then ask the question again, for example "So what is working to be even a 2 on this 'coping well' scale"...

## **REFERENCES:**

Korman, H. and Soderquist, M. (1993) *Talk about a miracle*. [www.sikt.nu/](http://www.sikt.nu/)

Korman, M. (2004). *Radical Simplicity with Complex Cases*. Workshop handout, Presented at the Brief Therapy Institute of Sydney, June 2004.

## **(Footnotes)**

- 1 After listening to Harry Korman and watching his work I now usually also say "I need to let you know I can not guarantee that I will be useful, only that I will try to do my best ... and I assume" (looking for the nod) "that you also will try". Harry has advised that he in turn is following Steve de Shazer in using this sort of statement. Eliciting this agreement about doubt / hope, ownership and effort is an important part of the context of our working together, a part of what I believe Harry describes as the "Common Project".
- 2 Michael Durrant, I believe, attributes the origin of this statement to Steve de Shazer.
- 3 In some cases particular attention must be paid so that the scale does not set up the conversation around the 'anti-problem'. It is more useful to focus on the presence of a solution than the absence of a problem. I find, for example, that with 'anxiety' I need to be particularly mindful of this.

**Part two of this article (E, E, & M) will appear in the March 2006 issue of Solution News.**

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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](mailto:letters@solution-news.co.uk), indicating clearly whether you intend your correspondence for print or solely for consumption by the Solution News team.**

Dear Editor

I like Solution News so much that I have spent £800 on a new computer that runs on Windows XP, and therefore supports Adobe Reader 6, and committed myself to a Cable Broadband Provider to supply it. Thanks for your help with my difficulties getting the News under Windows 98. There comes a point with technology when trying to keep

it running generates more problems than it solves. Perhaps not only with technology?  
Best wishes and keep up the good work

Ellis Roberts

***Thanks Ellis. What better reason could there be for upgrading your computer?  
- Ed.***

# The Professional Service Users

## **Per Ljungman reports on the “Expert Service Users” workshop at the 2005 European Brief Therapy Association conference in Salamanca, Spain (22 – 25 September 05)**

This conference on solution focused and related work has for me been an annual highlight of great learning and inspiration. It's set in different European locations over two to three days with commonly a couple of joint plenary-sessions a day and two daily workshop-sessions of individual choice (from about six to eight different sessions at a time).

As I was hurrying for my chosen workshop on the Saturday morning, I soon realized that the small lecture-room for my first choice of workshop would be overcrowded and I went off to visit my second choice: “Expert Service Users”. Had I known what I was going to experience this would had been my first choice for the whole conference! Sadly, the quite big hall where this workshop was taking place was empty but for eight participants, the four presenters and some conference hostesses. The arranging committee must have seen this as one of the most important workshops, giving them the space they deserved and the ‘conference general’ himself being one of the few participants. But the average conference participant (yours truly included I'm afraid) seems to sometimes hunt more for well known presenters (the devils you know...) rather than trying out new presenters that might have something really original to say. Nuff said!

The quartet of presenters at this workshop proved to be among the most qualified I've had the pleasure of learning from during the six EBTA-conferences I have attended. The greatest reason for this was, I think, that they poured so generously from their own life-experiences, each one having unique inside-knowledge, including:

- living with experienced ‘psychiatric problems’
- suffering from a mental health care system that is problem focused and that builds up more problems rather than being of help
- finding ways to cope through solution focused thinking and
- helping others to empower themselves through solution-focused support

**Veronica ‘Vicky’ Bliss** is the admirable founder of ‘The Missing Link Support Services’ through which she's been able to be of great help to the other three presenters among others.

Introducing her work and her three colleague-presenters she also reveals her own ‘CV of diagnoses’ including obsessive-compulsive disorder, autistic tendencies, depression, anxiety and hypochondrias. She also has a M.A. in Counselling Psychology and is working on one in SFBT



**Per Ljungman describes himself as a proud solution focused therapist at a public consultancy called NOVUM in Hässleholm in the south of Sweden.**

**More information on the Missing Link Support Service can be found at [www.missinglinksupportservice.co.uk](http://www.missinglinksupportservice.co.uk)**

as well. I wondered which of these are of the most use in her work.

'The Missing Link' is a solution focused watering hole in a desert of problem focus. It offers an opportunity for all those who fall 'in between services' to get their 'missing link' – somewhere where they themselves are respectfully listened to as people. And it seems to be a great community of people supporting each other, being able to take great pride in this belonging.

**Marina Whiteside** is a remarkable woman who has gone through loads of trials in life including 30 years in mental health services. Listening to her it becomes obvious that these "services" were of little or no service to her since they refused to listen to what she needed and herself knew would be of help to her.

A hilarious but horrifying example was when Marina, seemingly having been regarded amongst 'experts' as more or less a loony, was subjected to at least one genuine loony in the disguise of a psychiatrist. This 'professional' started to dance like a chicken trying to convince Marina to do the same thus illustrating the coward she was told she was.

She has been given the diagnosis of 'psychotic depression' and even been registered as a drug addict through just accepting the medicines she was prescribed. Now she copes well enough with life but still can't get a job because of her diagnosis. Luckily she's strong enough to see that what society values and what is of real value differ a lot sometimes. Therefore she shares her valuable experiences and keeps supporting others in need.

**Genevieve Edmonds** is a young woman of a brilliant mind. Unfortunately she's had to suffer from numerous efforts to stuff her into 'professional experts' frames of reference. She's had some use of her diagnosis of aspergers syndrome that makes sense to her, but besides that people tried to apply numerous diagnoses along with different

kinds of therapy / counselling and myriads of pharmacological treatments to her that was of little or no help. What did help was the solution focused approach where establishing problem-causes was irrelevant but focusing on Genevieve's goals, strengths and resources in her frame of reference – just accepting what she said – made the difference.

Now she has written three books and is of great help to others who employ 'The Missing Link' to survive the impact of mental health services in their lives.

**Emma Loughlin** is a very strong, humorous, charming and aggressive young lady. Thank God she's aggressive since it made her survive a childhood where too many were just too mean to her. But then others, including 'professionals' in mental health care, fixed on her aggression as one of their

problem identifications, as if she was the cause and not the victim. Despite this, through her strength and courage she managed to survive until she met someone who saw and listened to her instead of their own ideas. Solution focused therapy gave her tools to establish a new self-esteem. Her negative labels were renamed as good things, and she had attention attracted to all her good qualities including

that she was caring, strong, capable, adult, useful, pleasant to be with, etc.

Emma has a diagnosis of learning disability and it's useful to her in the predominant frames of reference in today's society because it makes her a living.

Considering the great resources these four women showed us at their workshop, certainly all of them, not only the formally professional one, should be granted recognition through wages, formal titles and appreciation. Until that happens, we all have to be grateful and take every opportunity to meet and listen to them and their equivalents when they invite us to share their great and most important self-acquired knowledge.

"The Missing Link offers an opportunity for all those who fall in between services to be respectfully listened to as people"



## **A Merry Holiday Season from the SOLUTION GNUS!**

**Recent doubts expressed by readers as to the true nature of the 'solution gnu' have led us to providing you with some more details what we know of our plain-roaming pals...**

**SOLUTION: a homogeneous mixture in which something (but not unix) is dissolved into a liquid.  
[as defined by MSN nucleus]**

**GNU: The wildebeest (from Dutch "wild animal"), is a large hooved (ungulate) mammal of the genus *Connochaetes*, which includes three species, all native to Africa: the Black Wildebeest (*C. gnou*), the Blue & White-bearded Wildebeest or Blue Wildebeest (*C. taurinus*), and the Solution Wildebeest (*C. shazerus*). The gnus belong to the family Bovidae, which includes antelopes, cattle, goats, and other even-toed horned ungulates  
[as defined by Wikipedia]**

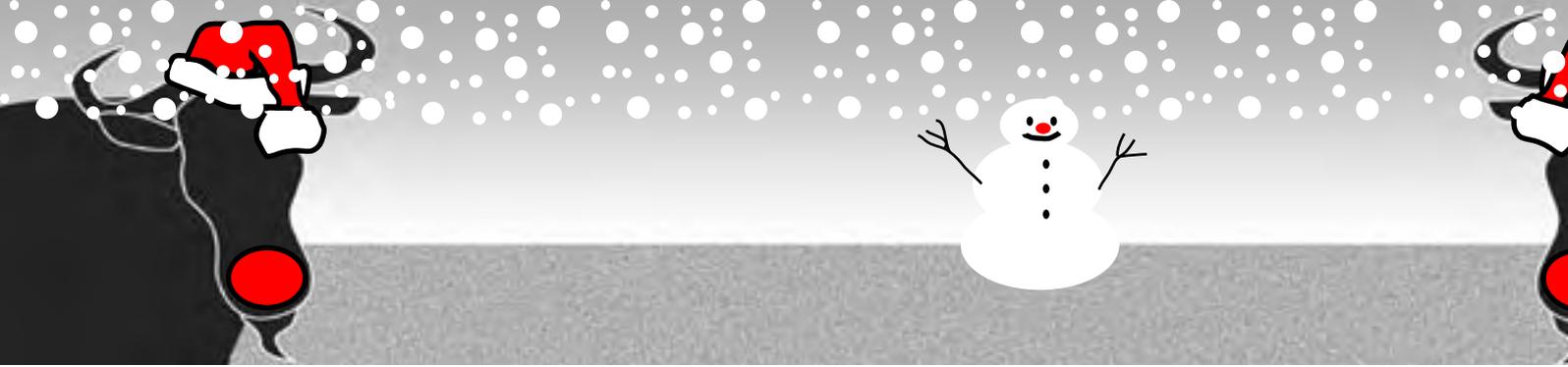
**Well, we hope that clears things up. Whatever their true nature, the mysterious mammals are still answering your questions. Here's wishing you all a happy gnu year!**

**"Dear gnus, I've heard that some universities and private companies are now offering long courses in solution focused working. I'm a bit confused as I thought that once you'd done a four- day course you would have learned all you needed to know. Can you enlighten me please?"**

***Bill O'Connell gnu. He said:***

As the person who designed and led a two-year solution focused training course in the UK (the MA) I have been asked a version of this question on many occasions!

Obviously, you can learn about working in a solution focused way from doing a four-day course, as you can learn to play the guitar or tennis on a four-day course. In other words, it is an introduction – to an ever fascinating and exciting journey!



In my view you can learn a lot about solution focused techniques in four days, but if you want to be solution focused in your values, your way of thinking and behaviour, then you need to invest far more of yourself than you do on a four-day course.

This learning can sometimes take place 'on the job', but that is not always possible. You also need the support of people sympathetic to what you are trying to put into practice. A longer training course can provide the space and support for busy practitioners to reflect, discuss, write and present their work.

In my experience, solution focused practitioners are committed to continuing to develop their skills and their knowledge. Few would ever dream that they had "learned all you needed to know."

Practitioners who privilege the client's knowledge, skills and strategies are only too aware of how little they know about anything...and how useful that can be!

What can you achieve on a longer course of SF training? I would suggest four gains:

- A better understanding of the philosophy, particularly the linguistics, which underpin the approach.
- A clearer sense of self in the work, so that you don't get in the way of the clients' solutions.
- Accountability for your work through supervision and peer group practice groups, while at the same time learning from the work of your peers.
- A more creative and imaginative use of the solution focused skills repertoire.

However it happens, most people find that once they experience the 'deep magic,' they are forever drawn to Solution Land!

## **"Dear gnu, are there any circumstances under which using solution focused techniques might be ill-advised or dangerous?"**

***Guy Shennan gnu. He said:***

I was once working with a rather feisty woman who lived in a tough part of Leicester. She arrived for a session one day – it was probably our third or fourth – and before I could ask her "what's better?" she said "I've had a bloody awful week, and if you start asking me any of those bloody scale questions, I'll clock you one!" That was a time when using a particular solution focused technique would probably have been ill-advised and possibly even dangerous...and I doubt I went on to start with "what's better?" either. So if we listen hard enough – and sometimes we will not have to listen so hard – our clients, through their unique ways of cooperating, will let us know when not to use certain solution focused techniques and when to do something different.

Shifting from particular techniques to considering the approach overall, in the latest instalment of his outcome studies published in the Journal of Family Therapy, Alasdair Macdonald (2005)



reports effectiveness rates in line with other studies – 76% - and adds his finding that when the approach is ineffective, it does not appear to be harmful. Our current knowledge-base does not enable us to predict in advance who will and will not be helped by solution focused brief therapy, but we do know that it is likely to help three out of every four people who walk through our door. So, on first meeting someone it would appear to be well-advised to use solution focused brief therapy, and that it will be safe to do so. And the best and safest advice we will receive as the work progresses will come from listening to our clients.

Macdonald, Alasdair (2005) Brief therapy in adult psychiatry: results from fifteen years of practice, *Journal of Family Therapy* 27 (1), 65-75

## MORE FROM THE GNUS NEXT ISSUE...

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# DISTRIBUTION NEWS

***Solution News* is going far and wide. As at 24.12.2005:**

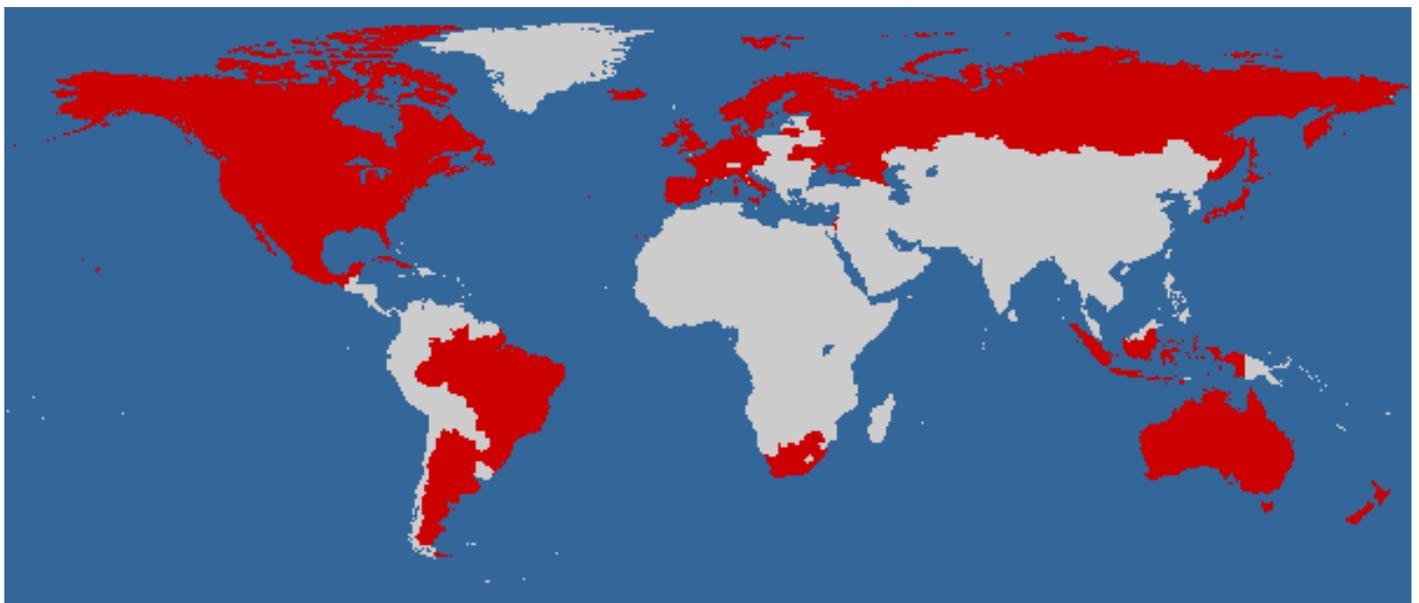
The total number of computers that had downloaded a copy of *Solution News* issue 3 was 723

The total number of 'first time' visitors to the *Solution News* web-site since launch was 779

The total number of countries *Solution News* had been downloaded from was 33

We also know that many of our readers get given *Solution News* in hard copy form by colleagues who have downloaded it, and these (obviously) aren't included in the above figures

## Countries Where *Solution News* Is Read, In Red!



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# 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](mailto:news@solution-news.co.uk).**

## **Announcements this issue:**

Member Rayya Ghul says: "Alasdair Macdonald, Rayya Ghul, Ron Banks, Paul Hackett, Sue Young, Paul Jackson, Steve Myers, Judith Milner, John Wheeler & Yvonne Greaves from the UK all had contributions published in: Thorana Nelson (Ed.), (2005), *Education and Training in Solution-Focused Brief Therapy*. Haworth Press. That's pretty impressive!

***I've read it and it certainly is! – Ed.***



Member John Wheeler would like to give you all advance notice that Insoo Kim Berg will be running a two day workshop on solution focused work with families for Gateshead Council on 26 & 27 June 2006 in Gateshead, Tyne & Wear, UK. The cost will be £150 plus VAT. Expressions of interest can be made to Marian Spurr at [MarianSpurr@gateshead.gov.uk](mailto:MarianSpurr@gateshead.gov.uk).



Interested in Solution Focused Training? Member Carole Waskett reports: Ten people – from people with flourishing training work

to those with a tentative interest – met on the 10th December 2005 at Harplands Hospital in Stoke on Trent, UK, to explore possibilities around forming a trainers' network for mutual interest, support and exploration. Training in the SF way is a fascinating activity. Conversations blossomed as we realised we were all deeply interested in how to do it, how to do it better, how to stay non-expert, how to stay respectful, how to offer various exercises, how to manage payment and insurance, and a dozen other issues. Energy and respect flowed, and so did individual conversations at tea-breaks, and so did the delicious biscuits and fruit people had brought. What a great and uplifting meeting!

As in most good training sessions, we emerged glowing and with an action plan:

- Two meetings a year – one in the morning just before the UKASFP conference and one other.
- A place on the Association website.
- Lots of creative ideas about how we could work with each other, with great respect for the individual preferences and quirks of various members.

We're now a network, name as yet undecided, with a new sense of belonging and solidarity. Do please come and join us, on the smartgroup and / or at the June conference. One more thing: how do you stop people talking about something they're excited about?



The fledgeling network of people talking to each other about sharing solution focused ideas in London and the south-east of England almost managed to meet up for the first time just before Christmas, if the end of term hadn't gotten in the way! A new meeting is planned in London for January to discuss how we can all best share ideas and support each other. If you are interested in coming along, please contact [ian.smith@hpt.nhs.uk](mailto:ian.smith@hpt.nhs.uk) for details of the date and venue.



## **NEXT ISSUE:**

**Client perspectives on solution focused working, more training materials, and nothing else unless someone sends some new articles soon!**