# Focus on Solutions A Health Professional's Guide

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# Contents

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# Preface

Anyone who is unwell at home or in hospital knows how important it is to be able to look at life beyond 'the problem'. This book gives an account of clients who have been able to find hopes and goals for the future despite struggling with a variety of physical, functional and psychological difficulties. Their quality of life has been helped by a solution focused approach which encourages clients to explore what they want different in their lives.

In 1997 I had been working for four years in North London with an 'elderly' client group (65+). I heard a colleague give a short presentation on Solution Focused Brief Therapy (SFBT) and instantly I was hooked! It sounded as if there was a way of working that treated clients in a more respectful way and that made more sense, especially with an older client group, than much of what I had learnt as a speech and language therapist (SLT) in college.

My enthusiasm for the approach remains as strong today as on that first day, not just because I have learnt more about it through attending training courses, workshops, conferences and reading books but, more importantly, I can see that it works. Both clients and colleagues comment on how SFBT has changed their lives for the better.

This book is a description of how a group of practitioners have used working with solutions to improve their quality of care. I now work in Central London in an acute hospital seeing clients aged 18+ who have either been admitted as inpatients or are seen in the Speech and Language Therapy Department as outpatients. Occasionally I see people in their homes if they become too unwell to come to the hospital. Most of the case examples given in this book are of clients I have seen who have communication and/or swallowing difficulties as a result of a stroke, a stammer, Parkinson's disease, traumatic brain injury, HIV, cancer, voice or memory problems. Unlike many therapy books the chapters here are not divided according to different

impairments, since I start from the assumption held by solution focused practitioners that these clients, like anyone else, have common dreams and hopes.

SFBT has become increasingly important in the health and education services. Doctors, psychologists, adult psychiatry teams, health visitors, counsellors and teachers are just some of the professions who have been trained in this approach, and it has also been used in coaching, appraisal and strategic planning in business. There is extensive literature dealing with alcohol and drug abuse, family breakdown or psychiatric problems and how clients have benefited from SFBT. To date, however, there has not been much written on its application with the client group in this book, and whenever I have given any talks on the subject there has always been a keen interest in specific examples. It is for this reason that I agreed to bring together over seventy case examples so that others can read, enjoy and learn from these clients' stories.

It is hoped that whatever your profession — therapist, nurse, doctor or psychologist — you may find something new and of interest. For example, you may not have thought it possible to see a client with significant physical impairment and be persuaded that together you have achieved what they need in only one session.

An introductory chapter to SFBT is given for those who are unfamiliar with what Steve de Shazer would describe as a way of talking rather than an approach. The book is designed to be read from the beginning; when you get to Chapters 4 and 5 you will be familiar with many of the questions included in the sessions described. It aims to address a number of issues that arise from using a different mindset. This challenges some of the ideas held in traditional caseload management and how we involve other professions, students and families in our work. To help demonstrate effectiveness, care aims and outcomes from case examples are included as well as data from studies that have used SFBT.

# Chapter 1
# Introduction to Solution Focused Brief Therapy

> Traditionally, scientists have measured the outcomes of health conditions by relying on mortality data. More recently, the international concern about health care outcomes has shifted to the assessment of functioning at the level of the whole human being, in day-to-day life. (WHO, 2002)

Since the first version of the International Classification of Functioning, Disability and Health (ICF), which provides a language and framework for the description of health and disability, was published in 1980 there has been a shift in emphasis from looking at people's disabilities to focusing on their level of health. There is now the recognition that it can be more helpful to measure the impact rather than the level of impairment itself.

Disability is an interaction between features within a person and the context within which they live, so that both medical and social responses are appropriate. Some aspects of disability however are 'entirely internal to the person, while another aspect is almost entirely external' (WHO, 2002). To reflect the biological, individual and social aspects of health, the ICF disability and functioning are viewed as interactions between health conditions and contextual factors. They consider body structure and function, activity and participation (the whole person and how they function in a social context) and environmental/attitudinal factors.

There is growing awareness of the importance of psychosocial elements in health care. Crises can undermine clients' self-esteem and belief in their own personal competence, and while clinicians spend a considerable amount of time analysing the output and input abilities of clients with communication difficulties, less time is given to looking at the levels of depression or anxiety of clients or their carers (Brumfitt, 1998). You may feel such areas require lengthy, in-depth help beyond your level of expertise. But effective rehabilitation needs the environmental and attitudinal areas addressed, and a psychologist, social worker or counsellor may not be readily available.

Solution Focused Brief Therapy (SFBT) can generate a feeling of hope towards achieving change and it has the ability to promote a more positive attitude towards problems or disabilities. The approach assists clients and carers in realizing that they are capable of getting through a crisis. It gives anyone working within the hospital, school or home environment a set of tools to work with so that clients can deal with emotional issues more effectively as well as establish goals more easily for day-to-day functioning. There is a simplicity about it which is often lacking in other models of therapy, and because it translates what the client is feeling into very practical 'doing' activities, it fits well into our case management.

SFBT helps you assume competency in yourself and in those with whom you work. It encourages change to be seen in small steps, rather than the team thinking in absolutes where results are seen as good or bad.

## History of solution focus

'Solution Focused Brief Therapy' was pioneered through the work of Steve de Shazer, Insoo Kim Berg and their colleagues at the Brief Family Therapy Center (BFTC) in Milwaukee, Wisconsin (brief-therapy.org), the term first being coined in 1982. Drawing on the tradition of family therapy and the work of Milton Erickson (Cade and O'Hanlon, 1993) the approach has evolved over time, and includes a number of theoretical approaches; cognitive, behavioural, narrative, experiential and systemic. Working with individuals, couples and families to resolve a wide variety of difficulties, they have trained many professionals in their procedures at the BFTC and around the world.

> Whatever the cause of a problem might be, its continuation has something to do with the context or setting in which it occurs and the expectation that the problem is going to continue ... This assumption leads to the idea that any difference in behaviour, thoughts, feelings, perceptions, and/or context stands a chance of making a difference such that the complaint is resolved. (de Shazer, 1988, p. 57)

Exploring problem behaviour, de Shazer noticed there are times when the problem appears less or is absent altogether. An example he gives is of a depressed client who is able to describe times when he is slightly less depressed. This is called 'the exception to the rule'. When asked how he manages to do this, the client is able to identify some of his own resources and strengths that he is using to solve the problem. These exceptions form the basis to showing the client possible solutions towards moving forward.

Working on the 'solution' pattern of behaviours de Shazer noticed they begin to outweigh the problem patterns. As he does more of the things that help improve his mood, the client becomes less depressed.

## Brief therapy

Typical of the brief/strategic therapist is the avoidance of an elaborate theory of personality or of dysfunction, and a concern with how to intervene as briefly and as economically as possible (Cade and O'Hanlon, 1993). Meeting the demands of managed care was not, however, the idea behind solution focused therapy. As the team at Milwaukee refined their techniques over 25 years the number of sessions decreased, particularly as interest grew in exploring clients' hopes for the future rather than looking at the problems in the present or the past. 'Following the methods will lead to brief treatment without you forcing yourself to do brief therapy' (Berg and Reuss, 1998).

You will find those who make no distinction between the terms Brief Therapy, Solution Focused Therapy or Solution Focused Brief Therapy. This book will refer to the approach as Solution Focused Brief Therapy which is widely accepted as the Milwaukee Model. The Milwaukee team, still led by Steve de Shazer and Insoo Kim Berg, would be keen to emphasize that rather than using SFBT simply as a set of techniques, it is a way of thinking that follows some basic assumptions (Berg, 1991).

## Some basic assumptions

### If it ain't broke, don't fix it

Traditional hospital treatment emphasizes a medical, disease-oriented model. In contrast to the medical model, a health-oriented approach defines the client as the authority on what needs to change and how that will happen (Miller, Hubble and Duncan, 1996). This belief that the client is the expert in all aspects of their lives challenges the role of the doctor/therapist/teacher as the expert. You may have considerable expertise in dealing with certain situations but that does not necessarily mean you know all the 'right' or 'wrong' ways for the client to move forward. This accounts for some of the failures of treatment plans that tell clients what to do. Similarly, a client may have developed a way of dealing with a problem that could be classified as 'maladaptive'. A particular strategy used by someone who stammers would be an example of this. If it works for the client, don't fix it. Look into the reasons as to how it is helpful and another strategy may, or may not, emerge as useful to them.

### If it works, do more of it

Insoo Kim Berg describes a client, referred as 'suicidal', who walks into her office held up by two people:

*Insoo*: So ... How do you do that?

*Client*: Do what?
*Insoo*: Walk! It takes so much energy to move one foot in front of the other. How do you manage to do that?

When the client explains the reasons for her being able to come to therapy Insoo is able to identify strengths in the client and to come to the conclusion that she isn't at a high risk of self-harm. These strengths can be used by the client in other areas of her life to formulate solutions to her problems, so that the session becomes a time for solution talk rather than problem talk (Berg, 2000). As de Shazer discovered, finding out what the client does that can be utilized to build solutions involves eliciting the right kind of talk.

> If you do not ask about exceptions and successes, the client will not tell you. After all, what they are concerned about is the problem which drove them to seeking therapy. (de Shazer, 1988, p. 158)

Your client may be in hospital with very real and pressing difficulties. Eliciting the 'right kind of talk' should not have the perceived effect of trivializing the problems. Hence the belief that SFBT is simple but not easy, and the best way to become familiar with the kind of questions asked is to watch or read about sessions with clients.

### If it doesn't work, do something different

You may find this applies to the clients who have been doing some dysarthria exercises for facial weakness and no apparent or perceived change has occurred. Rather than try and try again, do something different. Finding interventions and suggestions that are individualized to fit each client with unique sets of circumstances is the practitioner's job, and your task is to utilize the changes clients create themselves in the most positive way possible. The Buddhist idea that change is inevitable and happening all the time is an important concept in SFBT, and can be helpful to remember when clients appear to have reached a plateau in their care management. In general system theory, the principle that a difference or change in one part of a system will lead to repercussions in other parts of the system is well established.

Take the example of a client with voice difficulties. The relationship between voice, emotion and physical state has long been recognized by those working with voice (Martin and Darnley, 2004). The client may have tried various suggestions regarding voice care, such as avoiding dry atmospheres or alcohol and resting the voice, but it appears to have made little difference. The difference that makes the difference could be looking at self-esteem; changes in this area will have an effect on the various

components that make up the vocal process. Lowered eye levels and slumped shoulders, tension in the shoulders, neck and jaw, shallow breathing patterns and a faster breath rate may all be greatly alleviated if there is some consideration given to a client's level of stress. One change to take some of the stress out of their lives can have a ripple effect towards finding solutions to problems with their voice.

**Key points to remember**

- If it ain't broke, don't fix it
- If it works, do more of it
- If it doesn't work, do something different

## The first session

It may not be possible or desirable to follow a format in the first session. Chapters later in the book will look at situations that arise when a client is seen in a hospital bed as opposed to your office or in their home; factors such as the length of the session and the cognitive abilities or awareness of the client will come into play and will determine what you can or can't do. A number of steps, however, can be used as a reference for core first and follow-up session structure. At the Speech and Language Therapy Department in the Chelsea and Westminster Hospital we have found the following headings useful. Based on those given to us when we were trained by BRIEF in London some years ago, we continue to find them useful today with our varied caseload.

### Problem-free talk

How you start a session with a client can communicate very clearly how you view the client as a person rather than a problem. A key way to demonstrate this is to engage in what is referred to in SFBT as problem-free talk.

For example, a client who has been referred for a swallowing assessment in hospital would not be asked immediately about difficulties associated with eating and drinking. If a client with Parkinson's disease (PD) comes into your office as an outpatient and shows considerable difficulty getting into a chair, you would acknowledge this ('Take your time', 'It can be tricky, can't it?') but the aim would be to avoid if possible a lengthy discussion on their reduced mobility as a start to the session. The difference between problem-free talk and social chit-chat is that 'the therapist is on the look-out for clients' strengths and resources which may be helpful in resolving the problem'

(Sharry, Madden and Darmody, 2001). Asking the client with PD how the day is outside, or noticing some flowers by a patient's bedside allows you to connect with clients as people and can give immediate insight into their strengths and support systems.

Many would say that they already do this. In SFBT it is not only the practitioners' questions and comments that matter, but how the clients answer that help you focus on the next step. The person with physical difficulties may tell you that it's pouring with rain, the taxi didn't arrive and they got lost getting to your office:

*Therapist*: So despite the rain, the taxi and getting lost, you arrived here on time! How did you manage that?
*Client*: I'm very stubborn and determined. And I always allow a lot of time in case something happens.
*Therapist*: Have you always been such a determined and organized person?

Not only has the client been able to recognize strengths in himself, but the therapist can compliment him and use them to explore other examples of when these existing resources are used by the client to overcome difficulties. And all within a few minutes of the client coming in through the door!

### Problem definition

Moving on to what the client hopes to achieve by coming to therapy, you need to establish clear client-centred goals to ensure an effective outcome. Clients need to say in their own words what they want to work on, and it is sometimes surprising how different their perceptions are from those who referred them.

Consider the case of a 61-year-old client with Parkinson's disease who was referred by his doctor for help with his 'huskiness of voice'.

*Therapist*: Your doctor has referred you here. Perhaps you'd like to tell me in your own words ... How can I be helpful to you?
*Client*: I have a weak voice as a result of Parkinson's disease. I dribble a bit. Sometimes I have a problem with my swallow. None of them are chronic but they bother me. My consultant gave me the impression that I should just get on with it, but the thing is ... it's happening to me, not to him ... and I would like some help.

Notice the initial question. You don't ask 'What's the problem with your voice?' You ask an open ended question, which in this example allows the client to list clearly his own needs as well as convey an underlying message that he feels he needs to be listened to.

It may be that the carers will be asked this opening question if the client has difficulties with comprehension, but the information it provides is invaluable in terms of focusing on therapy goals.

### Goal for the session

Getting the clients to measure their criteria for success within a session, as well as looking at the outcome of therapy as a whole, is good practice. They will begin to notice for themselves the changes they are making towards finding a solution and not be dependent on what the therapist determines as measurements of success. It also allows for the SFBT belief that every session can be seen as the last; at the end of the first session practitioners will usually tell the clients that they would like to see them again and hear about what is going better, but in later sessions they ask clients whether they think they need to meet again. 'Such questions begin to send a message to clients that they are competent to decide what is best for themselves' (De Jong and Berg, 2002).

Useful starting questions are:

* What are your hopes for the session?
* How will you know this session has been useful to you?
* What will it take for you to say it's been worthwhile coming here today?

The reply may be one that looks more like a miracle and may mean that you don't do 'the miracle question', which will be explored later in this chapter. Clients who stammer, for example, may say 'I'll feel more confident.' In SFBT you want concrete, achievable goals, but it may be at this stage that clients are unable to translate feelings into 'doing things'.

Above all you are looking at the clients' language, and noting down what they say to feed back to them as a reminder, or to pass on to others. Their own words can be much more meaningful to them than ones chosen by you. You are not training to use a model here. You are developing your listening skills and your ability to notice, in collaboration with the clients, the potential solutions to their problems.

### The miracle question

'The miracle question is a central intervention in the solution-focused repertoire' (O'Connell and Palmer, 2003). Hypothetical solution questions – imagining what life will be like without the problem – are not new in the world of therapy, but the power of the miracle question was discovered accidentally by Insoo Kim Berg in the early 1980s.

She asks the question slowly and gently, using frequent pauses to allow for the clients to absorb what is being said, and the effect is quite mesmerizing. Video recordings show that many clients break into a smile and their eyes light up as they begin to describe in detail how their lives will be transformed.