

advances

in psychiatric treatment

journal of continuing professional development

Solution-focused brief therapy

Chris Iveson

APT 2002, 8:149-156.

Access the most recent version at DOI: [10.1192/apt.8.2.149](https://doi.org/10.1192/apt.8.2.149)

References

This article cites 0 articles, 0 of which you can access for free at:
<http://apt.rcpsych.org/content/8/2/149#BIBL>

Reprints/ permissions

To obtain reprints or permission to reproduce material from this paper, please write to permissions@rcpsych.ac.uk

You can respond to this article at

<http://apt.rcpsych.org/cgi/eletter-submit/8/2/149>

Downloaded from

<http://apt.rcpsych.org/> on May 1, 2013
Published by The Royal College of Psychiatrists

Solution-focused brief therapy

Chris Iveson

Solution-focused brief therapy is an approach to psychotherapy based on solution-building rather than problem-solving. It explores current resources and future hopes rather than present problems and past causes and typically involves only three to five sessions. It has great value as a preliminary and often sufficient intervention and can be used safely as an adjunct to other treatments. Developed at the Brief Family Therapy Center, Milwaukee (de Shazer *et al*, 1986), it originated in an interest in the inconsistencies to be found in problem behaviour. From this came the central notion of 'exceptions': however serious, fixed or chronic the problem there are always exceptions and these exceptions contain the seeds of the client's own solution. The founders of the Milwaukee team, de Shazer (1988, 1994) and Berg (Berg, 1991; Berg & Miller, 1992), were also interested in determining the goals of therapy so that they and their clients would know when it was time to end! They found that the clearer a client was about his or her goals the more likely it was that they were achieved. Finding ways to elicit and describe future goals has since become a pillar of solution-focused brief therapy.

Since its origins in the mid-1980s, solution-focused brief therapy has proved to be an effective intervention across the whole range of problem presentations. Early studies (de Shazer, 1988; Miller *et al*, 1996) show similar outcomes irrespective of the presenting problem. In the UK alone, Lethem (1994) has written on her work with women and children, Hawkes *et al* (1998) and MacDonald (1994, 1997) on adult mental health, Rhodes & Ajmal (1995) on work in schools, Jacob (2001) on eating disorders, O'Connell (1998) on counselling and Sharry (2001) on group work.

My colleagues and I at the Brief Therapy Practice in London work routinely with all age groups and problems, including behavioural problems at school, child abuse and family breakdown,

homelessness, drug use, relationship problems and the more intractable psychiatric problems. With the latter there is no claim being made that the cure for schizophrenia or any other psychiatric condition has been found, but if a woman with schizophrenia has the wish to get back to work or one with depression wants to enjoy caring for her children then there is a good chance that these goals will be realised and, in many cases, maintained. In brief, it is a simple all-purpose approach with a growing evidence base to its claim to efficacy.

The therapeutic process

As the practice of solution-focused brief therapy has developed, the 'problem' has come to play a lesser and lesser part in the interviewing process (George *et al*, 1999), to the extent that it might not even be known. Instead, all attention is given to developing a picture of the 'solution' and discovering the resources to achieve it. A typical first session involves four areas of exploration (Box 1).

The earlier emphasis on exploring exceptions to the problem has been replaced by an interest in what the client is already doing that might help achieve the solution. This has led to a new assumption that all clients are motivated. Initially, the issue of motivation was dealt with by a classification system (customer, complainant and visitor) similar to that used in motivational interviewing (Miller & Rollnick, 1991), depending on the client's attitude to the problem. The emphasis on the preferred future has made the client's view of the problem redundant to the therapy. All that clients need is to want something different – even if at the starting point they do not think that something different is possible.

Box 1 Four key tasks for a typical first session

Task of therapist

Find out what the person is hoping to achieve from the meeting or the work together

Find out what the small, mundane and everyday details of the person's life would be like if these hopes were realised

Find out what the person is already doing or has done in the past that might contribute to these hopes being realised

Find out what might be different if the person made one very small step towards realising these hopes

Examples of opening questions

What are your best hopes of our work together?
How will you know if this is useful?

If tonight while you were asleep a miracle happened and it resolved all the problems that bring you here what would you be noticing different tomorrow?

Tell me about the times the problem does not happen
When are the times that bits of the miracle already occur?

What would your partner/doctor/colleague notice if you moved another 5% towards the life you would like to be leading?

Scales

One of the most useful frameworks for a solution-focused interview is the 0 to 10 scale, where 10 equals the achievement of all goals and zero is the worst possible scenario. The client is asked to identify his or her current position and the point of sufficient satisfaction. Within this framework it is possible to define ultimate objectives, what the client is already doing to achieve them and what the next step might be (Fig. 1).

The scale framework can be used to differentiate different aspects of the problem and its solution. For example, a person with depression might feel devalued by colleagues. Each of these aspects might be explored through separate scales. Similarly, when the client is experiencing multiple problems, each problem can be addressed with its own scale. Where

several scales are used, areas of overlap soon become apparent, which helps the client realise that movement in one area can lead to improvements in others.

Coping and compliments

Looking for the client's strengths and resources and commenting on them is an important part of a solution-focused therapy session.

Sometimes clients' lives are so difficult that they cannot imagine things being different and cannot see anything of value in their present circumstances. One way forward is to be curious about how they cope – how they manage to hang on despite adversity. In one case, a therapist was asked to see Gary, a long-term in-patient at high risk of suicide. Gary could see no future, nothing of value in his present, was not going to cope any longer and was going to

Points to mark

10 – The perfect solution

7 – A good but realistic outcome

3 – Where the client is now

0 – The worst scenario

What to explore

The miracle question as a means to encourage creative thinking

A realistic description of the client getting on with his/her life without the problem interfering too much. The more concrete and realistic the better, since it is the small, mundane aspects of living that go together to make a good-enough life

Everything the client is doing that has helped him or her reach this point on the scale and/or everything he/she is doing to prevent matters getting worse

Best not to go into detail

Fig. 1 The scale framework

end it all. The therapist wondered at the courage and perseverance that had led Gary to endure 2 years of 'hell' and asked about his previous life. It was full of ordinary achievements and successfully met responsibilities, which the therapist suggested might have given him the strength to handle his current crisis. He agreed but thought he was running out of resources. When the therapist asked him to describe how he would know that he had just sufficient resources left to see him 'round the corner' Gary said he would try electroconvulsive therapy (ECT) again. Recognising the extent of the client's problem and complimenting him on his courage and perseverance were the key interventions in this case. Hospital staff recognised this and when Gary agreed to a further course of ECT they supplemented the treatment by seeking opportunities to compliment him. He was discharged 3 months later.

Subsequent sessions

On average, solution-focused brief therapy takes about five sessions, each of which need be no more than 45 minutes long. It rarely extends beyond eight sessions and often only one session is sufficient. If there is no improvement at all after three sessions, it is unlikely to work (although the three sessions are likely to provide most of the information required for a more traditional assessment). If possible, the time between sessions is lengthened as progress occurs, so a four-session therapy might extend across several months.

As it is the therapist's task to help the patient achieve a more satisfying life, follow-up sessions will usually begin by asking, 'What is better?' If there have been improvements, even for only a short time, they will be thoroughly explored: what was different, who noticed, how it happened, what strengths and resources the patient drew on in order to effect the change and what would be the next small sign of the change continuing. Scaling questions provide the simplest framework for these explorations.

If the situation has deteriorated, the therapist will be interested in how the patient coped and hung on through the difficulties and what he or she did to stop the situation deteriorating further. It often turns out that there have been considerable improvements that the patient had not noticed, having been too preoccupied with the problem to notice the inroads being made. In one case, a woman reported that her situation had worsened: not only did she still have her eating disorder but she was now having difficulties with her husband. In the process of looking at how she coped despite these increased difficulties it turned out that she had reduced her vomiting from

several times a day to several times a week and that her arguments with her husband were a product of her more assertive position in the family. She went on to overcome the eating problem and establish a relationship with her husband that suited them both.

Summary

The difficult part of solution-focused brief therapy is developing the same fluency in asking about hopes and achievements as most of us have when asking about problems and causes. But the guiding framework is extremely simple, as Fig. 2 shows. Most first sessions will start at the top left of this flowchart and then move down through the right-hand column. However the session goes, it will end with compliments. Subsequent sessions are likely to concentrate on the second and third boxes in each column: more to the left if progress is slight and more to the right if things are progressing well. In all sessions attention is paid to the overall goal and each session ends with compliments relevant to the achievement of that goal.

Case example 1: Exceptions to the problem of agoraphobia

Mrs Brown was agoraphobic and was seen at home. It is unusual for agoraphobic patients not to go out at all (children have to be taken to school, dogs walked, shopping done) but it seemed that Mrs Brown's case was so severe she had not stepped out of her front door for several months. Indeed, as the therapist's fruitless search for exceptions progressed, the problem description became ever more concerning. It turned out that Mrs Brown could not even bring her milk in off the step because being near the front door could set off a panic attack. The therapist had noticed that the stairs came down right beside the front door and after listening very seriously to Mrs Brown's worries, asked about the courage that it must take her to come down stairs each day. When she realised this was an absolutely serious question the tenor of the interview began to change. She said it was true that coming downstairs was difficult for her, because she had to pass the front door, but it 'just had to be done'. As the conversation progressed it turned out that Mrs Brown sometimes sat quivering at the top of the stairs but so far had forced herself to come down because she could not bear the consequences of giving in to this aspect of her fear.

The more her daily courage was explored and acknowledged the stronger became her voice. She then began to remember other acts of courage, like saying to herself the day before 'Don't be silly' and bringing in the milk or some months earlier when she had made herself attend her aunt's funeral because her aunt had loved her. As she became aware of this hidden but persistent courage, Mrs Brown began to put it to greater use and over the following

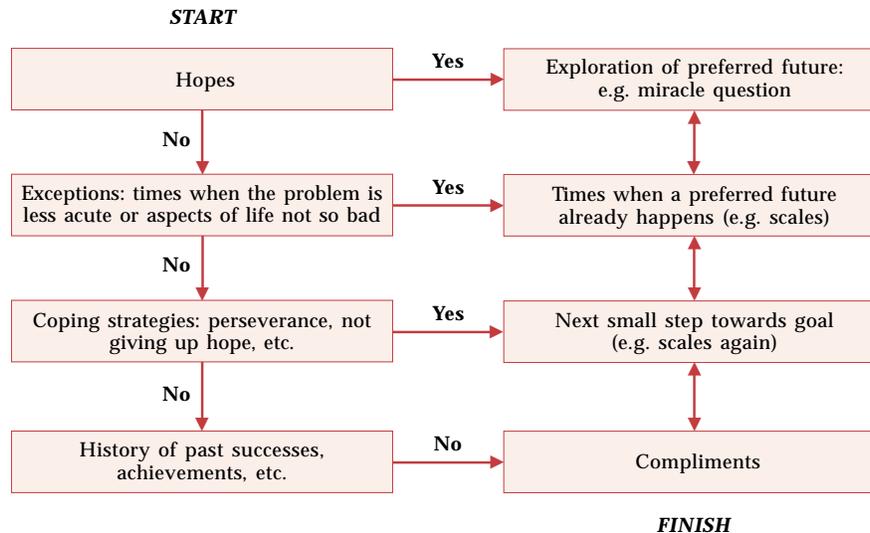


Fig. 2 The 'flow' of a session

weeks, with two more clinic sessions to support her, she made her way back into the outside world.

Case example 2: A future without eating problems

Mrs Black had suffered from an eating disorder for 12 years. She alternated between self-starvation and binge eating, although since her late teens had kept reasonably good control of the extremes. But she was becoming tired, despondent and depressed. Most of the first interview she spent answering questions about how her ordinary everyday life as a young mother, wife and woman might be different if the eating problem were resolved. She described the difference it would make to her thoughts, feelings and actions from the moment of waking. She described not only what she herself would notice different but also what family and friends would notice. By the fourth and final session she had been eating normally for several weeks.

In a subsequent interview with another professional about the process of therapy she said that she had know by the end of the first session that she would resolve her problem. Until then she had not seen a way forward so had assumed that there was none. The painstaking process of her answers and the description they had given of an alternative way of living had charted out a path which she knew she could take. Two years later the referring professional reported that Mrs Black was still eating normally.

Case example 3: A reluctant client

What follows are sections of transcript from a single-session therapy with John, a 35-year-old 'street drinker' with a prison record and currently subject to a probation order requiring him to attend an alcohol rehabilitation centre. The therapist is visiting the centre and will only see John once. The transcript is intended to show the 'small print' of a session – how the way the questions are asked and their closeness to the client's answers leads to the uncovering of an underlying but so far hidden motivation.

Therapist So John, what are your hopes for this session?

John I don't know.

Therapist What do you think?

John I suppose it will be useful.

Therapist In what way do you hope it will be useful?

John I don't know.

Therapist What do you think?

John Stop me drinking.

Therapist So if this meeting helps you stop drinking it will have been worth your while?

John Yes.

Therapist So can I ask you some unusual questions?

John Sure - I've seen so many doctors and people, I'm used to it!

Therapist Okay, here's an unusual one – let's imagine that tonight while you're asleep a miracle happens and your drink problem is resolved. But because you're asleep you don't know. What will you notice different in the morning that begins to tell you that drink is no longer an issue for you?

John I don't know, I can't imagine that.

Therapist Have a go!

John I don't believe in miracles.

Therapist No, neither do I but it's very helpful for me to have an idea about how you want your life to be so we can move in the right direction. So what time would you be waking up?

John About nine.

Therapist And what's the first thing you'll notice yourself doing differently that begins to tell you a miracle has happened?

John Nothing will be different – I'll get up, take some stuff to clear my head, have a coffee and go out.

Therapist Stuff?

John I'll take anything, anything I can get hold of, pills, the lot. It helps clear the head.

- Therapist* So let's say the miracle stops you needing stuff as well as drink. What will be different when you go out?
- John* Look, what you have to realise is that 90% of my friends drink, so what do you expect me to do?
- Therapist* No, it's certainly not easy – so what might you do if drink and drugs are no longer a problem?
- John* I don't know, there's all sorts of things.
- Therapist* So what might one of them be?
- John* [with a resigned sigh] Okay, the library, maybe I'd go to the library and look at the papers.

Solution-focused brief therapy, like all other talking therapies, relies on the creative power of the spoken word. John is beginning to describe what he thinks is an unlikely future, yet it is one that fits at least one aspect of his hopes and so far it contains nothing unrealistic. The more clearly it is described the more possible it will become. The idea of a 'miracle' to achieve the goal of the therapy proves a useful way to bypass some of the psychological blocks to thinking about a different future.

The session continues by drawing out, question by question, what would be different about his day if he went to the library. As his description progresses John becomes patently more interested in his account. Each time a possible block arises the therapist invokes the 'miracle', not to remove the block but to ask how John would deal with it if drink and drugs were no longer a problem:

- John* The thing is, it's impossible to concentrate on anything because I'm always worrying about money.
- Therapist* So what would you notice about the way you worried about money if drink and drugs were no longer a problem?
- John* Well, then I'd have to do something about it, wouldn't I?
- Therapist* So what might you be thinking of doing?
- John* Well, I can get work if I need it – I do gardens.

The therapist makes no attempt to advise or encourage John to 'perform' any of his described activities and simply ends the session by complimenting John on his honesty, his continuing interest in fighting his problem, his loyalty to his drinking friends and his courage in continuing to live such a hard life.

The Centre staff who had known John for a number of years reported a major shift in John's attitude after this session. He began to cooperate with the treatment programme and, although it took another year, he was eventually discharged. At follow-up a further year later he was working, still finding life hard but no longer using drugs or drink as a way of dealing with his difficulties.

Case example 4: Using scales to score a 'historic goal'

Adam was one of many young people in difficulty at school seen by my colleagues and I. He had been

excluded temporarily on several occasions, moved to a 'cooling off' unit, and been given one last chance. Adam said he did not want to be excluded, mainly because it would upset his mother, but he hated school and described all the teachers as picking on him. In the second session he could only report one change for the better: in football.

The therapist decided to try following this track (Selekman, 1993) and asked Adam to rate his football abilities on a 0–10 scale compared with all his friends. He put himself at 9. The next 30 minutes were spent exploring in great detail what it took to become that skilled at football. At first Adam said 'because I like it', but as the conversation progressed many more significant factors began to show: practice, perseverance, teamwork, humour, quick thinking, decision-making, fitness, reliability, loyalty, accepting discipline and self-discipline all turned out to be important components, even though Adam had been largely unaware of them until this interview. Another scale was then drawn in relation to school, with 10 being no problems and 0 being permanent exclusion. He put himself at 2. The therapist asked Adam which of his football skills had been most helpful to him in avoiding permanent exclusion so far. He said he always turned up for school (as he did for football practice), he sometimes did as the teachers told him (accepting discipline) and occasionally he worked (because he 'decided' to). Finally, the therapist asked him which other football skills he would find himself using if he moved from 2 to 3 on his scale. He thought and picked self-discipline, the quality he had been most proud to discover in his football scale.

By the fifth and final meeting with Adam he was doing well across all his classes, including history, which he thought he would never work in because it was so boring. When asked how he did it, Adam said it was self-discipline and the realisation that it was less boring to work than to mess about.

Single-session therapies

All therapists from Freud to the present have 'single-session successes', but by and large these are seen as flukes. O'Hanlon (O'Hanlon & Wilk, 1986) learned much about brief therapy by interviewing therapists about such successes and identifying common factors, one of which was a focus on the future. Talmon (1993) and Hoyt (1984) identify and describe many of the characteristics of the single-session case. In solution-focused brief therapy, single-session transformations are common enough not to be a surprise. There are three possible explanations for this.

First, some clients are stuck in the problem mainly because they do not know the way out. The detailed description of a preferred future that normally characterises the first session becomes a sufficiently

clear pathway for them to move off down it. Although there were three follow-up sessions in the case of Mrs Black (example 2 above), she had overcome the eating side of her difficulties by the second: the rest were focused on her dealing with the repercussion of the change on her everyday relationships (for a single-session eating disorder case description see George *et al*, 1999: Ch. 5).

Second, some clients have already solved their problem but have not yet realised this. When they describe their preferred future they see that enough of it is already happening for them to continue without further therapy.

Third, in the process of reviewing their circumstances, measuring their hopes against their knowledge of reality and taking stock of what they already have, some clients come to a realisation that their lives, although not perfect, are perfectly manageable.

The following case examples describe two successful single-session interventions.

Case example 5: Being quiet

Ossie was 5 years old and on the verge of permanent exclusion from school because of 'out-of-control' and aggressive behaviour. He came from a large family and his mother was seriously disabled by multiple sclerosis, which was in a state of rapid advancement. Grandparents were helping out but there was major friction between family members and between the family and the multi-professional network. A 'full assessment' of Ossie had concluded that he was developmentally at a pre-nursery stage and so was unable to comprehend what was required of him at school, let alone do any of it. The brief therapy meeting was a last-ditch attempt to retrieve the situation and although it was attended by Ossie's mother, his teacher, the special needs teacher and his grandfather it was clear that no one had much hope of a good outcome.

In a session with more than one person the task of the therapist is to offer each participant a chance to describe his or her version of a preferred future and to explore what might be potential contributors to its realisation. In essence, the meeting is like a series of short, interwoven individual sessions.

Ossie was engaged in a few minutes of 'problem-free talk', then each person was invited to declare his or her hopes (all related to Ossie's behaviour at school) and then scales were used to mark Ossie's (very limited) progress towards the goal of good behaviour. For Ossie it was important to find a 'language' that he could use. Contrary to the assessment results, Ossie had both a complete grasp of school routines and regulations and a wish to work hard and stay out of trouble. He was invited to describe a good day at school by demonstrating sitting quietly, lining up quietly and walking in a line quietly. Everyone was asked to join in this demonstration, in which Ossie showed not only how he wanted to be but also his ability to be it.

As the meeting developed, teachers and family began to report many hitherto unnoticed signs of

progress and by the end hope for Ossie's future had been rekindled. The fact that Ossie knew much more than had been apparent before the meeting goes a long way to explain his rapid advancement from an 'impossible' to a 'good' pupil.

Case example 6: Remembering tomorrow

Don had been advised to seek residential care for Brenda, his wife who had Alzheimer's disease. The referral for therapy was because he would not take this advice. Both he and Brenda said that their lives would be much more manageable if Brenda could remember more. The 'miracle' they were invited to explore was not the full return of Brenda's memory but her ability to make the fullest use of the memory power she still possessed. Step by step, Brenda managed to remember and describe everything that she had planned for the next day: this included doing her Christmas shopping with her daughter, the time her daughter would call and the effect on her daughter when she found that her mother not only remembered she was coming but also remembered who she was buying presents for and which shops she wanted to visit. In similar detail Don described what he would see different about his wife and the effect this would have on him and on their lives together.

Don and Brenda both became interested in the idea of remembering recent occasions when Brenda's memory seemed to work. They said that it was very refreshing to discover that all was not lost.

Two weeks later the couple returned, not for more therapy but just to let the therapist know that they did not think they needed any more sessions. They were in very high spirits and laughing when they said that they had thought long and hard but still could not work out if Brenda's memory had improved or it was simply not a bother to them any more. Whatever the reason, it was no longer a problem. Some years later their daughter contacted the therapist to say that her father had died but how grateful she and her parents had been for the session that 'had given them back their marriage'.

In both of these single-session examples, as in many others, the improvements lasted over at least 2 years of follow-up. They were also situations in which it would have been impossible to predict that one session would be sufficient. There is no evidence that solution-focused brief therapists are unique in producing such outcomes but they are probably more open to them since their expectations are not restricted by diagnostic formulations.

A complementary treatment

Although solution-focused brief therapy is a treatment in its own right it can also be used to complement other treatments. In the cases of Gary and John above, both were seen as part of a much

wider complex of treatments. The best that can be said is that the solution-focused brief therapy sessions helped each client to orient himself more effectively to the treatments that eventually worked.

One area of work in the clinic in which I practice is dealing with family breakdown. A family might be attending an intensive residential treatment centre and use occasional solution-focused brief therapy sessions to assist the working of the treatment plan. A first meeting might explore the question, 'If this stay in the centre was to be 100% successful what would be different on the day after your discharge?' or, 'If this placement turns out to be just what you need, how will the staff know that it is working?' Questions such as these help construct the signposts of success while allowing the main treatment to do the work. In a similar way general practitioners can use questions such as the following to orient their patients towards the signs of improvement and cure rather than just focusing on symptoms, which can have the effect of amplifying them:

- If these antidepressants work, how will you know? What will be the first sign that your mood is lifting?
- It sounds as though you have had a terrible time – what do you think has enabled you to cope with such courage?
- If we were to begin reducing your medication what do you think will tell us we are going at the right pace?

These are all questions that invite the patient to contribute his or her own expertise to the overall treatment programme in a way that is most likely to complement the primary treatment. The same is true in physical medicine, for instance, oncology, where the patient's attitude is likely to have an effect on treatment efficacy and outcome.

Conclusion

The complementary nature of solution-focused brief therapy is in part a product of its location outside conventional 'scientific' knowledge. In science, words are used to describe and delineate 'reality' and for something to be regarded as 'real' it must be possible to replicate it. The theoretical underpinnings of solution-focused brief therapy are to be found more within the realms of philosophy. It is based on an understanding of language and dialogue as creative processes. Because the central focus is on the future and because there is no framework for 'understanding' problems, there is little for patient and therapist (or therapist and therapist!) to disagree over.

However, the lack of a diagnostic structure in solution-focused brief therapy creates problems for the measurement of its efficacy. Most studies rely on client or referrer report and have little objective validity. However, a study on the treatment of recidivists after prison discharge (Lindfors & Magnusson, 1997) has shown significant effectiveness. A major international research initiative, using accepted 'scientific' measures as well as new, more solution-focused measures, is currently being coordinated on behalf of the European Brief Therapy Association (<http://www.EBTA2001.com>) by Alasdair MacDonald. If this supports the findings of earlier studies then solution-focused brief therapy will have a significant part to play among the many treatment possibilities afforded by modern psychiatry.

References

- Berg, I. K. (1991) *Family Preservation: A Brief Therapy Workbook*. London: BT Press.
- & Miller, S. (1992) *Working with the Problem Drinker: A Solution Focused Approach*. New York: Norton.
- de Shazer, S. (1985) *Keys to Solution in Brief Therapy*. New York: Norton.
- (1988) *Clues: Investigating Solutions in Brief Therapy*. New York: Norton.
- (1994) *Words were Originally Magic*. New York: Norton.
- , Berg, I. K., Lipchik, E., et al (1986) Brief therapy: focused solution development. *Family Process*, **25**, 207–221.
- George, E., Iveson, C. & Ratner, H. (1999) *Problem to Solution: Brief Therapy with Individuals and Families*. London: BT Press.
- Hawkes, D., Marsh, T. & Wilgosh, R. (1998) *Solution-Focused Therapy: A Handbook for Health Care Professionals*. Oxford: Butterworth-Heinemann.
- Hoyt, M. F. (1984) Single session solutions. In *Constructive Therapies* (ed. M. F. Hoyt). New York: Guilford.
- Jacob, F. (2001) *Solution-Focused Recovery from Eating Distress*. London: BT Press.
- Lethem, J. (1994) *Moved to Tears, Moved to Action: Brief Therapy with Women and Children*. London: BT Press.
- Lindfors, L. & Magnusson, D. (1997) Solution-focused therapy in prison. *Contemporary Family Therapy*, **19**, 89–104.
- MacDonald, A. J. (1994) Brief therapy in adult psychiatry. *Journal of Family Therapy*, **16**, 415–426.
- (1997) Brief therapy in adult psychiatry – further outcomes. *Journal of Family Therapy*, **19**, 213–222.
- Miller, S., Hubble, M. & Duncan, B. (eds) (1996) *Handbook of Solution-Focused Brief Therapy*. San Francisco, CA: Jossey-Bass.
- Miller, W. R. & Rollnick, S. (1991) *Motivational Interviewing: Preparing People to Change Addictive Behaviour*. New York: Guilford Press.
- O'Connell, B. (1998) *Solution-Focused Therapy*. London: Sage.
- O'Hanlon, W. H. & Wilk, J. (1986) *Shifting Contexts: The Generation of Effective Psychotherapy*. New York: Guilford.
- Rhodes, J. & Ajmal, Y. (1995) *Solution-Focused Thinking in Schools*. London: BT Press.
- Selekman, M. (1993) *Pathways to Change: Brief Therapy Solutions with Difficult Adolescents*. New York: Guilford Press.
- (1997) *Solution-Focused Therapy with Children*. New York: Guilford Press.
- Sharry, J. (2001) *Solution Focused Groupwork*. London: Sage.
- Talmon, M. (1993) *Single Session Solutions*. New York: Addison-Werlely.
- Weakland, J. H., Fisch, R., Watzlawick, P., et al (1974) Brief therapy: focused problem resolution. *Family Process*, **13**, 141–168.

Multiple choice questions

1. Solution-focused brief therapy is based on:
 - a clear diagnostic formulations
 - b appreciating the client's resources
 - c a detailed description of the client's problem
 - d the scientific study of personality
 - e the use of language as a creative process.
2. Solution-focused techniques involve:
 - a the 'miracle' question
 - b paradoxical injunctions
 - c complimenting the client
 - d careful administration of medication
 - e the patient's acceptance of the problem.
3. Solution-focused brief therapy has been effective in the treatment of:
 - a drug and alcohol misuse
 - b agoraphobia
 - c adolescent behavioural problems
 - d eating disorders
 - e chicken pox.
4. Solution-focused authors include:
 - a de Shazer
 - b Lethem
 - c Rollnick
 - d O'Hanlon
 - e White.
5. Scaling questions are used to explore:
 - a the patient's achievements
 - b the patient's description of the symptoms
 - c medication requirements
 - d possible areas for progress
 - e goals of therapy.

MCQ answers

1	2	3	4	5
a F	a T	a T	a T	a T
b T	b F	b T	b T	b F
c F	c T	c T	c F	c F
d F	d F	d T	d T	d T
e T	e F	e F	e F	e T

Commentary

Michael Göpfert

I wholeheartedly support the publication of Iveson's paper (2002, this issue), although I have misgivings about it. I hope that my contribution will clarify this seeming contradiction. When I first encountered solution-focused therapy in the 1980s, a new world opened up before my eyes: all those patients with whom I had got stuck could be offered another opportunity of making progress. At the time I was particularly engaged with somatising patients, who mostly did not want to

see a mental health professional because they seriously believed that their problems were of a somatic nature and needed an expert to provide solutions for them. For those patients solution-focused therapy provided a unique opportunity, as it clearly addressed issues within a psychological realm, yet I could take the stance of the expert who could prescribe solution-focused thinking as a sometimes helpful way of alleviating otherwise often intractable problems.

For example, a patient with irritable bowel syndrome required all the tricks from the toolbox of solution-focused therapy but after a year's period of work, with sessions at increasing intervals, a significant degree of symptomatic relief and reduction in unhappiness had been achieved. This had been maintained in the face of adversity at the 6 month follow-up interview. Approximately 18 months later the person requested further time-limited in-depth work. Solution-focused therapy did not provide a miracle cure, but provided for a patient who was suffering significantly, and was difficult to help.

From my experience, the more short-term effective work might be easier to achieve in general psychiatric settings with an absence of waiting-lists and freshness and non-selection of problems. The average psychotherapy department in the National Health Service (NHS), with long waiting-lists and a relatively high level of complexity among the problems referred, might well have good use for solution-focused skills, but sometimes without the shine of quick and sometimes virtually miraculous work. It is the quick and miraculous improvement that can often cause some suspicion of the genuineness of solution-focused therapy. Just as with governments, if there is too much spin and not enough visible substance people cannot trust what is on offer.

I learnt about this on a case in which solution-focused work with a whole family produced dramatic and amazing changes in the identified patient (daughter) within a short period of time. However, her father's view was that nothing had fundamentally changed and the family terminated sessions. In view of this experience I would have liked Iveson to have explored in depth the complexities of solution-focused work with families.

Solution-focused therapy is most closely allied to the field of systemic and family therapies, although it also has much in common with cognitive-behavioural therapy. One of the dilemmas for the practitioner is that solution-focused therapy has to be applied in a fairly purist form. Problem-focused and solution-focused ways of talking cannot be readily combined. Undoubtedly, talking about problems can have the effect of reinforcing them

rather than helping to find solutions, and therefore solution-focused therapy can be invaluable for the generic mental health practitioner in any part of the mental health field. It also can be very useful for therapists of any persuasion, provided that they have the ability to differentiate and integrate therapeutic approaches. However, what Iveson does not tell us is that solution-focused approaches can be unhelpful with more complex problems. This especially applies to some people diagnosable as having a personality disorder and their families. I also believe that solution-focused practice can carry the risk of being positively harmful if it colludes with the often symptomatic desire of our clients for a quick fix. The lack of outcome studies with long-term follow-up data is particularly worrying in this respect.

To my mind, one of the biggest shortcomings of solution-focused therapy is that its training culture is that of private for-profit training enterprise, rather than reflecting the needs of NHS patients. We still do not know when and where it is most appropriate to use or to avoid solution-focused interventions. However, unless solution-focused techniques are much more solidly integrated into public sector mental health services this knowledge may remain an illusive goal. I understand that there are now major efforts underway to evaluate solution-focused therapy in the NHS.

Brief solution-focused therapy is not sufficiently substantial as a modality of therapy in its own right and as a framework it lacks explanatory power. Nevertheless, it is based on radical assumptions that make it different from other ways of therapeutic work. It can provide a set of tools that can be used in all areas of mental health to supplement and enhance therapeutic work. The examples in Iveson's paper illustrate this well. I hope that it will encourage the reader to learn the elegant simplicity of solution-focused therapy, which can be very effective and easy to grasp.

Reference

Iveson, C. (2002) Solution-focused brief therapy. *Advances in Psychiatric Treatment*, **8**, 149-156.