Common Questions about Solution Focused Approaches

Alasdair J Macdonald

Abstract

This article seeks to address some common questions and issues about SF approaches. First it examines some objections raised to SF work and the interplay between SF and emotion. Cultural issues are mentioned and there is a discussion of when not to use SF methods. Theoretical perspectives about change and about the SF model are summarised. Links with cognitive-behavioural methods, motivational interviewing, Appreciative Inquiry and Positive Psychology are considered.

Introduction

This article seeks to respond to some questions often asked by those in training, especially those from other major schools of therapy. Such questions are also raised by families, often those who have experience of other counselling models. They are rarely raised by those whose experience of counselling is limited to television dramas, in which rapid recovery is commonplace. SF fits the pre-conceptions of the public, who have been reported to expect therapy to last 5–6 sessions of about half an hour each (Garfield, 1986). This may help its acceptability to clients, which is a strong predictor of good outcome (Wampold, 2001).

Objections to SF therapy

Some reviewers have suggested that SF therapy is regarded by many as too short, emotionally shallow and gimmicky. "Die bis heute überwiegende Mehrheit der im ericksonischen

Address for correspondence: 3 Beechwood Square, Poundbury, Dorchester DT1 3SS, United Kingdom

Feld und in der Lösungsfokussierung nach de Shazer arbeitenden Therapeuten bevorzugt deshalb indirekte, strategisch intransparente, fast 'tricksende' Interventionen"/ "Until now, the vast majority of therapists working in the Ericksonian field and in solution focus according to de Shazer therefore prefer indirect, strategically opaque, almost 'tricking' interventions" (Schmidt, 2010 (p. 79), translation: Kirsten Dierolf). However, much of this criticism comes from workers with allegiance to other trainings. Like most of us, they keep up with their own subject but do not read the evidence for other approaches. Those workers from any discipline who have had some training in SF work recognise that it is respectful of the client's autonomy and that it is not 'a quick fix' for every case.

A common question in workshops is 'Will it work with X diagnosis?'. In fact a very large range of diagnoses have been the subject of research (see SF evaluation list: www.solutionsdoc.co.uk; www.ebta.nu). All we can say is that no-one has yet found clear links between diagnostic categories and the response to talking treatments of any kind (Wampold, 2001). Findings so far confirm the importance of general and client-specific factors but not diagnostic classifications. In training workshops for SF therapists, further enquiry usually reveals that the questioner is thinking not of a specific diagnosis but of a specific 'stuck' situation with which they are working. A clinical discussion about how to apply SF methods to the situation may provide some new ways of moving forward, or reveal that no-one could do any more at the present time, whatever their model of care.

Another finding from this wide variety of research is that it appears to be feasible to combine SF thinking and talking with other approaches to managing situations (McKergow & Clarke, 2007). Business consultants use their own interpersonal skills, sometimes combined with existing analysis tools. These may include Appreciative Inquiry, motivational interviewing or existing management systems as well as SF. Similarly, combined treatments are common in mental health care, especially in complex cases.

SF therapy and emotions

Some schools of therapy believe that the experience of emotion by the client is the key to change, not simply talking about feelings. There is no doubt that emotion, positive or negative, often occurs at times of change, but which element is causative? Those with post-traumatic stress disorder constantly re-experience the emotions associated with the initial trauma, which they find distressing, not helpful. The events recalled have failed to become detached from the emotion of the moment and remain painful and frightening. The dearest wish of the sufferer is to reduce or stop such emotional experiences. Similarly, persons with bipolar affective disorder may have prolonged elevation or depression of mood. This does not appear to be a maturational process or a helpful one. Brain injury and Alzheimer's disease are often accompanied by labile and short-lived emotions with no visible benefit to the sufferer.

Most SF practitioners do not ask questions about emotions unless the client brings them up, in words or in behaviour. This is not the same as denying the expression of emotions by the client, which would be disrespectful. Everyone has emotions: we all experience every one of the major emotions at least fleetingly every day. However, there is no good evidence that enlarging on these experiences is helpful in bringing about change. See for example the work of Bushman et al. (1999) which suggests that catharsis makes people more aggressive, not less so. They found that aggression is not decreased if it is a success; it is repeated. What may be helpful within the SF model is to ask about what feelings might be experienced instead and how that will show itself to others in the person's life. The process is the same as addressing the person's goals for recovery instead of reiterating the details of the problem. This aspect of SF work is well discussed in de Shazer et al. (2007). Sometimes it is useful to reframe emotions, for example describing generic signs of emotional arousal as 'anticipation' instead of 'fear' or 'anger'. It can also be useful to use conversation to change

the context of emotions, for example asking, 'How do you do sadness?', 'How will your colleagues know when you are confident?'

Cultural issues

Another comment sometimes made about SF models is that they are 'too American' and not suited to dour British clients. This may be compared with the comments about Positive Psychology (see below). Naturally, the sensitivities and attitudes of clients have to be taken into account in all therapies. A major part of the SF approach is its emphasis on the client's perspective and language.

So far, SF work appears to be appropriate for many countries and cultures. We have seen comparison studies from China, Korea, Iran and Mexico. The Health Promotion system in Hangzhou, China, is adopting SF models. Textbooks are being translated into Mandarin and Cantonese. Fujioka (2010) has published a Japanese textbook of SF psychiatry. Insoo Kim Berg was herself a Korean native and taught widely in the Far East. India, Hong Kong and Singapore have had training workshops. SF management conferences have been held in Japan and South Africa as well as Europe. Doctors Without Borders, the American Red Cross and other aid agencies employ SF trainers to assist their work in African and other impoverished countries.

When not to use SF approaches

Often in workshops we are asked if SF is unsuited to some situations. This aspect was addressed by the Dutch management consultant Coert Visser (http://solutionfocusedchange.blogspot.com). In 2009 he identified three settings in which SF approaches might be less relevant.

If you have reason to think that the complaint primarily has to do with physical causes. For example, if the client complains about chest pain radiating to his left arm, suggest that he sees a doctor fast instead of asking the miracle

question. Similarly, if the problem of the client has to do with some kind of technical defect, such as a computer not working, it may be wiser to check the cables than to ask for exceptions to the problem.

If there is a proven standard approach for the type of problem. If your client asks you how to compose a job application resumé you might just hand him some examples instead of asking him scaling questions.

If there is an urgent situation or danger. In those cases you may not have enough time to lead from behind. Instead, you may first need to take some direct action. Perhaps after that, you may continue the SF conversation. For example, if a client discloses information about current sexual abuse, the rules of evidence and the possible summoning of other agencies may be relevant before you can proceed with any therapeutic activity.

In therapy the client is the person sitting opposite the therapist and the therapist's job is to help him to make his desired changes. In safeguarding children and vulnerable adults, these people are the client, present or not, and their needs are the primary focus. The protocol for safeguarding is different from any therapy protocol and is derived from legal statute. A worker may seek to balance both roles, but safety must always come before therapy. If during therapy it becomes clear that another is at risk then safety comes first even if this requires the breaking of confidentiality or action by the police.

Some clients have long-term or chronic physical illness, so there are certain changes they cannot make. Many such clients know that their bodily disability will not disappear and therefore find it difficult to use the miracle question constructively. For them, the most effective techniques are seeking for small goals 'which will be a first step for you', and to use exceptions and scaling. Nevertheless, Burns (2005) has used SF brief therapy with patients who have major physical disabilities. The use of SF approaches has been recommended for palliative care (NICE 2004) and cardiac rehabilitation (SIGN 2002). Given that management

tasks are often continuous, not one-off 'cures', this suggests that the same principles can readily be applied in many workplace situations.

Sometimes clients do not respond to SF therapy. In 2007 Margarita Herrero de Vega and Mark Beyebach presented a study of 'Solutions for "stuck cases" in SF therapy, at the EBTA annual conference in Brugge. They had identified 80 'stuck' cases in their practice, 'stuck' being defined as a failure to increase on the client's scale by session three. Their analysis of the cases suggested that those stuck at 5 or higher will respond to a change of therapist or to a different style of therapy. (See also Lambert et al. 2001.) Those stuck at 3 or lower showed more response to a change to another style of therapy than to a change of therapist. The use of feedback to therapists as a way of reducing 'stuck' cases from any model of therapy is also discussed by Lambert (2001).

The author's children used to say 'Don't use that brief therapy stuff with me!'. They wanted a parent's response, not that of a professional.

Theory and the SF approach

In this section I will examine some of the issues raised by other schools of thought regarding the theoretical aspects of therapy and where SF stands in relation to these others. Traditional psychotherapy, the behavioural therapies, Appreciative Inquiry and Positive Psychology all claim to address similar problems in the everyday world.

There has been criticism of the SF approach because it is said to lack 'a theory of change'. Such criticism comes mostly from the psychodynamic and humanistic practitioners, whose work is based on complex theories about human cognition and behaviour. They do not accept models of therapy which do not produce a detailed and often painful narrative of human life. This might be thought of as the Romantic movement within psychotherapy. These views are held even though it has been shown that all models of therapy

are equally effective (Wampold, 2001; Seligman, 1995). The mental mechanisms identified by Freud and others do appear to be real events which occur within all of us. These mechanisms can be detected in all the humans studied in the extensive psychoanalytic literature. However, behaviour change occurs without our requiring any knowledge of these mechanisms and knowing about these mechanisms does not resolve all the problems of daily life.

The opposite of the Romantic movement in literature is the Classical, exemplified by behavioural and cognitive-behavioural theorists. For them the theory of change is that inappropriate behaviour can and should be changed. However, Pavlov's original work on stimulus-response conditioning is not a complete support for this (Pavlov, 1926). There is a misunderstanding about Pavlov's work. Writing in the Russian language he talked of 'conditional' reflexes, that is, reflexes which occurred after certain previous conditions had been experienced. In translation this became 'conditioned' reflexes, implying that the reflexes were induced or inserted by the experimenter (see en.wikipedia.org/wiki/Ivan_Pavlov). This moved the focus of interest towards control by the experimenter and away from the innate abilities of the animal and from the context in which the reflexes were induced. This led behaviourism to be interpreted as a form of didactic process and less attention was given to the responses of the subject of the experiments.

Note that statistical tests could not be applied because, instead of the group studies which would be expected in the present day, Pavlov tested one dog at a time. Some dogs conditioned successfully; some dogs needed constant retraining; some never learned, becoming aggressive or immobile. Perhaps these latter dogs had personality disorder, or were not clever enough to learn, or were born anarchists. When Pavlov's laboratories were flooded by bad weather some dogs forgot everything that they had learned. The significance of this for human behaviour is unknown.

Also, human beings prove remarkably resistant to changing behaviour in spite of recognisable damaging consequences.

This applies in such examples as returning to violent partners, relapse of substance misuse, changing eating habits or choosing not to support a dictator. There are many studies of cognitive-behavioural therapy (CBT), mostly in depression and anxiety but in many other disorders also. Significant benefits are not found in all of these studies in spite of frequent assertions about the evidence base of this therapy. SF therapists believe that their work is unlike CBT. CBT work requires the assumption that the client thinks repetitive negative thoughts which can be usefully replaced by better thoughts proposed by the therapist, who is therefore an expert in relation to the client and to the client's thinking. SF therapists do not adopt an expert stance in relation to the client and are aware of the relative inefficiency of solutions generated by the therapist compared with those generated by the client. As SF therapy becomes better known, the textbooks and literature of CBT have gradually become more collaborative and client-centred. My colleague Kate Hart is a CBT trainer and describes her SF therapy as 'CBT by stealth'.

Steve de Shazer was a respected proponent of the work of Wittgenstein. Some of his books (1994; 2007) present what amounts to a theory of the SF approach in Wittgenstein's terms. This can be regarded as 'the theory of change in SF' if such a thing is necessary.

SF, CBT and other therapies change feelings through cognitive and behavioural routes. Methods for changing feelings directly are less common. Eye movement desensitisation and reprocessing (Shapiro, 2001) and hypnotherapy are sometimes effective in changing feelings directly without the involvement of cognitive processes and in advance of behaviour change. Although talk between client and therapist is used in these approaches, the talk need not focus on behaviour change or mood change (Peacock, 2001; Mahlberg and Sjoblom, 2004). Cognition follows afterwards or not at all (Isebaert, 2005). The use of Ericksonian hypnotherapy techniques in combination with SF therapy is described by Dolan and others. Similarly, many therapists combine narrative and SF approaches.

Narrative therapists believe that change will come about through certain sorts of conversations. However, they do not prescribe change and have no specific theory about how change will be achieved. They look to the client, the family and the community for resources and ideas. Their methods are well liked and respected by clients and communities.

In both therapy and business, motivational interviewing, Appreciative Inquiry and Positive Psychology all have features in common with SF therapy and are combined by some workers (see McKergow & Clarke, 2005, 2007; Mintoft, 2005). Motivational interviewing is used in the first stages of change; for action and maintenance one moves to other models. Appreciative Inquiry as a method can be enhanced through the use of the specific language skills and techniques found in SF teaching.

Positive Psychology (Seligman, 2002) highlights exceptions in the form of happiness and good moments in everyday life. It looks for the development of strengths and socially constructive actions as a form of therapy against depression, isolation and anxiety.

Positive Psychology emphasises self-esteem and confidence based on one's existing skills and resources. The assumption is that clients will be reassured by this and will move to resolve their difficulties. Again the theory of change is limited and the emphasis is on helpful, goal-directed conversations. It has been described as a rather grand way of saying 'Pull yourself together'. Extensive research projects, books and articles have been published. However, in daily life we see that most people are over-optimistic already. This appears in our estimates of journey times and our hopes for the sale price of our house. A quote from a Romanian audience: 'Hope is the biggest slut in the world: everybody lives with her.' (SOL 7/5/10, Bucharest). Positive Psychology has had considerable success in the United States and in the business community. Those from more reserved cultures such as the British and North European countries may find the style uncongenial.

Hubble, Duncan and Miller (Duncan and Miller, 1999) are

well-known for championing the importance of common factors in all therapies, against the concept that any specific therapy has 'the answer'. However, this does not invalidate the finding that therapists like one approach better than another, as do clients. If a therapist favours a particular model then his or her success rate with that model is higher (Wampold, 2001). Seligman finds that the client's choice of a model is also linked to outcome. Any one approach has a success rate of 60-70%, thus at least two approaches need to exist in order to help the majority of clients. Thus the need for different models and techniques is likely to remain.

SF therapists have become more willing to combine their work with other approaches if the situation requires it (Milner, 2001). Both sides still regard themselves as separate and different, but the techniques practised appear to be moving closer to each other.

In fact, some other widely accepted models of psychotherapy have no theory of change nor any theory at all. Interpersonal Psychotherapy (IPT) (Klerman et al., 1974) was invented using psychodynamic language. It was intended as a sham treatment for comparison with CBT in a joint trial of amitriptyline combined with talking therapy. In the trial it was found to be more effective than CBT. This may have been due to an allegiance effect in that generation of practitioners, who were mostly trained in psychodynamic styles. The trial outcomes led to further studies of the effectiveness of IPT and it is reified now as a treatment in its own right, solely on the basis of effectiveness in practice. IPT was not based on any theory of change and no personal therapy is expected of trainees. It is quick to learn and it is easy to obtain accreditation. IPT is one of two therapies approved by the NICE guidelines of the Department of Health in the United Kingdom for the treatment of depression (the other is CBT).

It seems therefore that lack of theory is not a bar to respectability, and that extensive theory does not guarantee success for our clients. However, we may be entering a period in which any specific therapy model is not clearly

separated from other models. The responses of the client may become the driver for the use of any particular technique or approach.

Conclusion

Many of the challenges presented to SF arise from the theoretical base of other models of psychological change. These are valid challenges. However, they are also challenges to the other models, since SF appears to work well in spite of these differences. Many of the objections raised about SF can be answered at a practical level within sessions. Research into SF and into psychological therapies in general has shown that no therapy is specific for any diagnostic category. There are times and settings for which SF is not the only tool or not the most useful. However, it has been found acceptable in a variety of cultures and countries, which is not true of every model of therapy.

References

Burns, K. (2005). *Focus on Solutions: A Health Professional's Guide*. London: Whurr Publishers.

Bushman, B. J., Baumeister, R. F. & Stack, A. D. (1999). Catharsis, aggression, and persuasive influence: self-fulfilling or self-defeating prophecies? *Journal of Personality and Social Psychology*, *76*, 367–76. (http://www.apa.org/journals/psp/psp763367.html)

de Shazer, S. (1994). *Words Were Originally Magic*. New York: Norton.

de Shazer, S., Dolan, Y., Korman, H., Trepper, T., McCollum, E. & Berg, I. K. (2007). *More than miracles: the state of the art of solution-focused brief therapy*. New York: Haworth Press.

Duncan, H. & Miller, S. D. (1999). *The Heroic Client: Doing Client-Directed, Outcome-Informed Therapy*. San Francisco: Jossey-Bass.

Fujioka, K. (2010). *Becoming a solution building psychiatrist*. Tokyo: Kongo Shuppan. (Japanese.)

Garfield, S. L, (1986). Research on client variables in psychotherapy. In S. L. Garfield and A. E. Bergin (Eds.), *Handbook of Psychotherapy and Behaviour Change (3rd ed.)*. New York: Wiley.

Hubble, M. A., Duncan, B. L. & Miller, S. D. (Eds.) (1999). *The Heart and Soul of Change: What Works in Therapy*. Washington: American Psychological Association.

Isebaert, L. (2005). *A Protocol for Depression and Anxiety*. Presentation, European Brief Therapy Association World Conference, Salamanca, Spain, 23–24 September.

Klerman, G. L., Dimascio, A., Weissman, M., Prusoff, B., & Paykel, E. S. (1974). Treatment of Depression by Drugs and Psychotherapy. *American Journal of Psychiatry, 131,* 186–191.

Lambert, M. J., Whipple, J., Smart, D., Vermeersch, D., Nielsen, S., & Hawkins, E. (2001). The effects of providing therapists with feedback on patient progress during psychotherapy: Are outcomes enhanced? *Psychotherapy Research, 11*, 49–68.

Mahlberg, K. & Sjoblom, M. (2004). *Solution-focused Education*. Stockholm: Mahlberg & Sjoblom. (Swedish edition Stockholm: Mareld 2002.)

McKergow, M. & Clarke, J. (Eds.) (2005). *Positive Approaches to Change: Applications of Solutions Focus and Appreciative Inquiry at Work*. Cheltenham, UK: SolutionsBooks.

McKergow, M. & Clarke, J. (Eds.) (2007). *Solutions Focus Working: 80 real life lessons for successful organisational change*. Cheltenham, UK: SolutionsBooks.

Milner, J. (2001). *Women and Social Work: Narrative Approaches*. Basingstoke: Palgrave / Macmillan.

Mintoft, B., Bellringer, M. E. & Orme, C. (2005). Improved client outcome services project: an intervention with clients of problem gambling treatment. *ECOMMUNITY: International Journal of Mental Health and Addiction, 3,* 30–40.

National Institute for Clinical Excellence (2004). *Improving Supportive and Palliative Care for Adults wth Cancer*. (www.nice.org.uk)

Pavlov, I. P. (1926). *Lectures on Conditioned Reflexes: Twenty-Five Years of Objective Study of the Higher Nervous Activity Behaviour of Animals*. English edition: New York: Liveright Publishing (1928).

Peacock, F. (2001). *Water the Flowers, Not the Weeds*. Montreal: Open Heart Publishing.

Scottish Intercollegiate Guidelines Network (2002; reviewed 2007) *No. 57: Cardiac rehabilitation*. (www.sign.ac.uk)

Seligman, M. E. P. (1995). The effectiveness of psychotherapy. The *Consumer Reports* study. *American Psychologist*, *50*, 965-74. (www.apa.org/journals/seligman.html)

Seligman, M. E. P. (2002). *Authentic Happiness*. New York: The Free Press / Simon and Shuster. (www.authentichappiness .com)

Shapiro, F. (2001). *Eye Movement Desensitization and Reprocessing (EMDR): Basic Principles, Protocols, and Procedures (2nd edn)*. New York: Guilford Press.

Schmidt, G. (2010). *Liebesaffären zwischen Problem und Lösung. Hypnosystemisches Arbeiten in schwierigen Kontexten*. (3rd edn). Heidelberg: Auer.

Visser, C. (2009). http://solutionfocusedchange.blogspot.com /2010/07/limitations-and-contra-indications-for.html

Wampold, B. E. (2001). *The Great Psychotherapy Debate: Models, Methods and Findings*. New Jersey: Lawrence Erlbaum Associates.

Dr Alasdair J Macdonald is a consultant psychiatrist, trainer and management consultant, and is the EBTA research coordinator. www.solutionsdoc.co.uk, macdonald@solutionsdoc.co.uk