A Solution-Focused Approach to Psychiatric Rehabilitation

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This paper relates the values of Psychiatric Rehabilitation (PsyR) to the strategies of solution-focused therapy (SFT), exploring the applicability of SFT in a PsyR setting. A review of the literature demonstrates that SFT complements the values and principles of PsyR and is a viable course of intervention throughout recovery for empowering persons with severe mental illness. The specific application of SFT to supervision and case management is examined.

Major transformations have taken place in the care of people with severe mental illnesses (SMI), such as bipolar disorder, chronic affective disorders, and schizophrenia. Formerly, a paradigm of long-term hospitalization, intense use of medication, and an extensive course of therapy were typical. Treatment now accentuates brief hospital stays, moderate use of psychotropic medication, and swift transition to the most integrated levels of care (Pratt, Gill, Barrett & Roberts 1999). Despite the major transformations in the therapist's role, little attention has been given to the degree of involvement of the person in therapy. People in therapy have too often been treated as passive recipients of therapy rather than active managers of their own recovery process (Heinssen, Levendusky, & Hunter, 1995).

To increase the involvement of people in therapy, Psychiatric Rehabilitation (PsyR) has instituted specific values to guide professionals and to support them in actively achieving recovery (International Association of Psychosocial Rehabilitation Services [IAP-SRS], 1996). PsyR embraces values that facilitate the recovery process by encouraging empowerment. Empowerment is defined as a psychological sense of personal control, involvement, influence, and awareness of options in one's life (Anthony & Blanch, 1989; Anthony & Liberman, 1986a; Deegan, 1992; Diamond, 1998; Rappaport, 1987). Recovery is more likely when people feel that they have options available (Evans & Sullivan, 2001; Ridgway, 2001; Young & Ensing, 1999). Deegan (1988) explains that when people have options or choices, a new sense of self and purpose is found. People can acknowledge the reality of the disability while grasping the distinction that the disability does not circumscribe or define their identity.
PsyR embraces five values or attitudes that guide how the PsyR practitioner views and interacts with people to facilitate recovery. First, the therapist communicates the person’s owning the right to self-determination. This means people in therapy participate in all decisions affecting their lives. Second, PsyR acknowledges the dignity and worth of every individual regardless of the degree of disability. Third, the PsyR practitioner is optimistic regarding the possibility of recovery: each person is putatively capable of recovering and achieving a satisfying quality of life. Fourth, the PsyR practitioner acknowledges every person’s capacity to learn and grow. Finally, PsyR recognizes the value of individual cultural and ethnic differences, without imposing cultural or ethnic boundaries (IAPSRS, 1996; Pratt, Gill, Barrett, & Roberts, 1999). Consider from a different viewpoint, solution-focused therapy (SFT) as a promising therapeutic approach that reflects and complements PsyR’s foundational values. This paper first provides an overview of SFT in the context of PsyR, examining their similarities of purpose and SFT’s value as an effective intervention. This is followed by a discussion of the application of SFT to supervision and case management.

Solution-Focused Therapy in the Context of Psychiatric Rehabilitation

Solution-focused therapy is fundamentally consistent with the values of PsyR. Forged through the efforts of de Shazer (1985; 1988; 1991; 1994), Berg (1994), Berg and Miller (1992a) and their colleagues at the Brief Family Therapy Center in Milwaukee, SFT is the product of 20 years’ work treating individuals, observing results, scrutinizing therapy sessions, and critically examining treatment procedures (Berg & De Jong, 1996). The correspondences between SFT and PsyR can be seen by pairing their major constructs: (a) self-determination/person in therapy as expert, (b) dignity and worth/drawing on person’s strengths, (c) optimism/solutions vs. problems, (d) individuals’ capacity to learn, grow and change through new meaning, and (e) cultural sensitivity/taking a collaborative stance (De Jong & Berg, 2002; IAPSRS, 1996; Pratt et al., 1999). A comparative review of these constructs highlights the relevance of SFT to the treatment of individuals with SMI.

Self-Determination/Consumer as Expert

Self-determination is an integral part of the recovery process in PsyR. Noted as one of the subjective outcomes (Anthony, 1993), self-determination is a process of reclaiming one’s options by taking control of choice. The individual becomes an expert in his or her own self-care (Deegan, 1992) and takes ownership of the solution (Berg & Miller, 1992a).

Solution-focused therapy emphasizes self-determination through its core belief that people “...are the experts about their own lives” (De Jong & Berg, 2002, p. 19). SFT affirms the reliability of individuals’ internal frame of reference throughout the solution-building process and charges the therapist with helping them to explore their frame of reference (De Jong & Berg, 2002). Helping in this context means awakening individuals to the fact that the solutions to problems rest within themselves, which places primary emphasis on the self-determination (Triantafillou, 1997). Through this approach, the individual holds the power to determine what is meaningful and important, thereby choosing to change through personal interpretations of meaning and not that of the practitioner.

Advocating personal choice, Chamberlin (1985) emphasized that it is not up to PsyR professionals to dictate where and how people should live. Both PsyR and SFT affirm the people’s right to choose how to live. Rehabilitation goals are centered around adjusting to one’s everyday life experiences (Anthony & Liberman, 1986a), therefore it is important that persons with SMI select therapeutic goals and the options for attaining them.

Dignity and Worth/Consumer Strengths

PsyR asserts that SMI does not diminish an individual’s worth, deserved respect, or personal strengths, despite great prejudice and discrimination (Deegan, 1992; Markowitz, 2001). Clinical wisdom demands that we respect the individual before all else (Deegan, 1995). However, the mental health care system in the USA has been criticized frequently for dismissing the opinions of persons with SMI (Stoul, 1989). When the mental health system becomes the locus of power and decision-making, the worth of individuals with SMI is eroded. The individual becomes more helpless, disempowered, irresponsible, and dependent (Deegan, 1992).

Solution-focused therapy provides an alternative to traditional counseling, demonstrating respect for dignity and personal worth by focusing on a solution geared to the individual’s concerns rather than dwelling on his or her problems. All clinical interaction proceeds on the assumption that all persons possess strengths, and the best way to assist them is to use their strengths and resources (Berg & Miller, 1992d). SFT explores the individual’s successes to discover what works. Repeated focus on strengths helps people recognize and increase their ability to control their lives. Berg and Miller (1992a) contend that it is more respectful to help people evaluate their own achievements or failures, rather than to rely on the therapist’s judgment (Berg & Miller, 1992c). Solution-focused therapy additionally reinforces
individual dignity by identifying problems as an entity separate from the person. For example, the practitioner might say, “You are working hard to block out the hallucinations, and right now it seems as though you are in control.”

Another means to draw on a person’s strength is to focus on what SFT calls exceptions. It is critical to SFT to identify times when individuals are not experiencing a specific problem (e.g., taking medications on time). The “exception question” is a powerful tool for people who present a problem such as hallucinations. Rather than focus on the problem, the therapist focuses on exceptions to the problem condition, asking about any times when there was no difficulty with hallucinations. The solution-focused PsyR practitioner asks what is different on the days without hallucinations, or what gives the individual greater control when hallucinating. A question to elicit such a response is, “What’s different when you experience hallucinations and are still in control?” (Miller, Hubble, & Duncan, 1996, p. 259).

The person begins to observe, learn, and grow in problem-solving ability by keeping track of their better moments. SFT suggests asking what happens when the problem ends or starts to end, discovering why the problem is not worse. Exception questions put the person on a more controlled course, using their strengths to learn and grow (Rowan & O’Hanlon, 1999).

Optimism/Solution vs. Problem

Optimism and the awareness that options are accessible are vital to overcoming difficulties and discouragement (Anthony, 1993; Crane-Ross, Roth, & Lauber, 2000; Deegan, 1995). Such optimism in PsyR can be expressed through the guiding principle called recovery (Ridgway, 2001; Spaniol, 2001; Torrey & Wyzik, 2000).

While the concept of recovery is still being refined within PsyR literature, several definitions have already evolved. Anthony (1993) defines recovery as “[a] way of living a satisfying, hopeful, and contributing life even with limitations caused by illness” (p. 15). Another school of thought views recovery not as the condition of being cured, but an attitude, a posture, or a way of taking on daily challenges (Deegan, 1995).

The literature leaves no doubt that many people have a strong desire to self-manage their disability, and have the potential to do so by coming up with creative and effective strategies (Young & Ensing, 1999). Having options is a critical need in recovery (Anthony, 1993), and each person’s attitude throughout recovery is unique. The person in recovery has acquired a means of processing ideas, feelings, goals, and strengths that engenders confidence about possible alternatives. Once aware of their options, people recognize that they have choices: they can then experiment; testing and retesting ideas and strategies to determine which ones best meet their personal needs. In this way people develop ways of coping. A self-determined person evolves out of this process—one who can learn how best to live beyond his or her disability.

Another SFT practice engages people in “solution talk,” discussion of potential, with the goal of arriving at solutions to bring about a productive and satisfying life. The practitioner asks questions that elicit personal strengths and resources people can draw upon during difficult times. The importance of solution talk is not to be underestimated: “The most challenging aspect of solution-focused therapy is knowing the right questions to ask” (McNeily, 2000, p. 37) and the appropriate language to use. A well-timed question can trigger a slight change for the individual, and, with the solution-focused practitioner’s support, the person can begin to work out the problem (McNeilly, 2000). Questions may vary in subtlety—from guarded questioning to plainly asking the person to focus on him or herself (De Jong & Berg, 2002). The solution-focused practitioner builds upon what has been said, basing successive questions on earlier answers (De Jong & Berg, 2002, p. 23). This approach is based on two principles: recognizing that the process of questions and answers leads to new awareness and possibilities, and the judicious use of follow-up questions to expand upon previous responses, always in a manner consistent with the individual’s weltanschauung (De Jong & Berg, 2002, p. 23). Consistent with the recovery model, this technique generates hope. The consumer becomes engaged in actively determining solutions; no matter what the problem or the resources. Since encouraging persons to make this shift is so important, de Shazer (1994) calls the change from talking about problems to discussing solutions, “solution talk.”

An overwhelming sense of hopelessness is a common problem among many people looking to recovery (Deegan, 1995). For many persons with SMI, illness has become so much a part of their identity that they become resigned to it and give up hope of improvement (Pettie & Triolo, 1999). One SFT technique that is often used to bring a new perspective is called the “miracle question.” The miracle question cuts the Gordian knot: the therapist asks how life would be different if a miracle occurred and their problem immediately vanished (De Jong & Berg, 2002; McNeilly, 2000). The person is asked to describe in detail the future events brought about by the miracle; this description aids in formulating consumer-centered goals that will re-
A useful tool for assessing process of change is scaling—assigning a numeral value (typically between one and ten) to the individual's perceived condition, improvement, mood, success, or other intangible. Scaling assists people in measuring their conceptions of past and possibly future circumstances.

Scaling simplifies complex experiences by asking people to grade situations quantitatively. For instance, on a scale of one to ten, where ten means the problem is solved and one is the worst the problem has ever been, a person can say where they are on the scale at the moment (Berg & De Jong, 1996).

Since the individual's judgment is of utmost importance (Berg & De Shazer, 1993), the SFT practitioner regularly asks people to rate their past, present, and possible future circumstances. The scaling question can then be used to approximate when a problem is solved (future), when it is the worst (baseline), and how it is at the moment (present). Scaling questions also allow for many different types of questions and levels of measurement (De Jong & Berg, 2002). For instance, scaling questions can measure a person's perception of self-confidence and helpfulness, the seriousness of a problem, the priority of goals, the degree of clinical growth, or the person's level of motivation to reach their goals (Berg, 1994; Berg & Miller, 1992c). As each individual works to accomplish clinical goals, scaling can reinforce personal strengths and again draw attention to the exceptions to the problem (De Jong & Berg, 2002).

Some kind of learning and change is almost always occurring in an individual's life. Therefore, it is possible for a person to frequently measure their preconceived amount of growth and change using the technique of scaling (De Jong & Berg, 2002). In PsyR as in SFT, people do not take huge steps in their process through recovery; rather, many small improvements can add up to extraordinary change (Anthony & Liberman, 1986b) as they experience positive feelings about small units of growth (Ridgway, 2001). As the opportunities present themselves, accomplishments can be measured in small manageable steps (Berg & Miller, 1992b; Christensen, Todahl, & Barrett, 1999; De Jong & Berg, 2002). Scaling may be a tool for people to better recognize various types and levels of accomplishments while learning and changing, and such awareness may help to motivate them towards recovery.

Another effective way to use scaling in SFT is relationship questions. Relationship questions provide “a second lens through which to view” oneself (Berg & De Jong, 1996, p. 389). The person is asked to recall interactions with others and to assign significance to these interactions. The scales in this exercise are used to measure what others would observe about them from the past, the present, or future. The person, then, in theory, becomes more aware of the responses of others by envisioning their reactions, what others would want to see happen, and how the person could bring about the necessary change. Imagining how a third party would scale progress offers insights to the practitioner as well (Berg & De Jong, 1996). When therapists were asked to rate the efficacies of various types of SFT questions, scaling was chosen as the best way to evaluate change (Miller et al., 1996).

Cultural Sensitivity/A Collaboration
Severe mental illnesses know no cultural or ethnic boundaries, requiring PsyR to serve a diverse group of people. Often, PsyR practitioners are advised about the importance of becoming culturally aware to ensure culturally competent services (IAPSRS, 1996). Anthony and Liberman (1986b) have stressed that the PsyR training
must be tailored to the needs of the individual. Anthony and Blanch (1989) reiterate the importance of bringing to the people's attention the community programs they want and need. Jacobson (2001) claims that it is important to discover what each individual perceives as meaningful in life, and not to assume that the meaning will mirror the practitioner's. When PsyR's values of cultural sensitivity are considered alongside the SFT strategies, it becomes evident that both are culturally receptive.

Cultural sensitivity is established in SFT strategies by using the "not knowing" position or the view of "individual as expert." Anderson and Goolishian (1992) introduce the term not knowing to describe the therapist assuming the role of student more than the role of an instructor: the therapist needs to better understand what the individual has said, and does not need to impose his or her own beliefs and expectations. The practitioner, no longer such a figure of authority, becomes a learner educated by the consumer (Anderson & Goolishian, 1992). Solution-focused therapy also shares this stance for collaborating with individuals (Berg & De Jong, 1996). The therapist or practitioner depends on the person in therapy as expert to determine his or her own needs and the practitioner simply facilitates communication, helping him or her express needs. This approach seems only prudent, given the awesome complexity of the personality. As De Jong and Berg (2002) put it, "...each individual is a composite of several dimensions of diversity (class, ethnicity, gender, physical ability/disability, sexual orientation, religion), and there is no way of knowing ahead of time how these may interact with one another..." (p. 257). Solution-focused therapy is a collaboration, promoting a dialogue that acknowledges each person, distinct, with their own personal view-

points and perceptions (De Jong & Berg, 2002).

Both PsyR and SFT believe in respecting the cultural differences of each individual. Although PsyR acknowledges the need to be culturally competent, SFT goes further: it holds that knowledge of one's culture is important, but it is even more important for the therapist to relate to the "individual's strengths, experiences, and idiosyncrasies" (De Jong & Berg, 2002, p. 258) in a posture of not knowing.

**Application of a Solution-Focused Approach in Psychiatric Rehabilitation Settings**

Deegan (1995) maintains that mental health practitioners have the power to transform clinical psychiatric settings into environments of hope, options, and choices. Deegan (1995) calls this an interactive environment where choice allows persons with SMI to become empowered. Torrey and Wyzik (2000) affirmed that when people make their treatment relevant to their own well being and needs, they are empowered. In order to create an overall environment of equality and empowerment, it is important that these values are integrated throughout the PsyR setting. Two key roles that can convey these values are supervisors and resource managers (earlier "case" managers). This section will discuss solution-focused techniques in supervision and resource management and the impact on overall outcomes.

**Solution-Focused Supervision**

Solution-focused supervision techniques have been effectively integrated into mental health settings (Marek, Sandifer, Beach, Coward, & Protinsky, 1994; Rowan & O'Hanlon, 1999; Triantafillou, 1997) and have been found to have a positive impact on outcomes (Presbury, Echterling, & McKee, 1999; Rudes, Shilts, & Berg, 1997; Triantafillou, 1997). Often, the organizational focal point in mental health agencies is on mistakes or problems (Rowan & O'Hanlon, 1999). Grasso and Epstein (1987) maintain that focusing on problem resolution does little to enhance supervisee performance. By contrast, solution-focused supervision promises to be a more productive approach than a problem-based approach (Berg & Miller, 1992e; de Shazer, 1988; Presbury, Echterling, & McKee, 1999; Rudes, Shilts, & Berg, 1997; Triantafillou, 1997). In addition, traditional methods of supervision are typically characterized by an imbalance of power between supervisor and supervisee (Triantafillou, 1997). By using solution-focused techniques, the supervisor functions as a facilitator, building on supervisees' resources and strengths (Marek et al., 1994), and persons with less power and choice have control within an organizational structure, and are not treated as automata to be directed (Segal, Silverman, & Temkin, 1995).

**Supervision Techniques**

"Focused supervision" is a solution-focused technique that concentrates on the dialogue between supervisor and supervisee and therefore attends to the actual words spoken. Minute observations of transactions between supervisor and supervisee (using a solution-focused approach) reveal an array of effective interpersonal techniques for counselors-in-training (Rudes, Shilts, & Berg, 1997). Supervisors take a position that is less authoritarian and more collaborative, and they focus on facilitating conversation to better understand the trainees' concerns. Rudes et al. found that "focused supervision" helped trainees to become aware of their nascent therapeutic skills, to take ownership of their personal growth and progress, and to assume the responsibility for evaluating their own personal development.
Another solution-focused technique, developed by Presbury, Echterling, and McKee (1999), is termed "inner vision." The mutual approach in this model establishes a collaborative supervisor-supervisee environment. Here the supervisee has an opportunity to develop through a progression of guided supervised steps, yet at the same time establish a personal therapeutic identity of their own (Presbury et al., 1999). Presbury et al. found that if trainees believe they are collaborating with the supervisor, they are less likely to focus on problems, and presumptively will have more opportunities and energy to build on their personal strengths. These researchers also found that when supervision is typified by an encouraging, collaborative, and solution-focused approach, trainees focus on their resources, and realize their unique identity as a counselor.

Trianatafilou (1997) applied solution-focused supervision techniques in a children's residential mental health setting. The children had family backgrounds characterized by conflict and presented with depression, hyperactivity, stress, anxiety, and oppositional behavior. The main purpose of this study was to ascertain if training in solution-focused techniques could have an encouraging or constructive effect on the children by improving supervisor and staff performance (Trianatafilou). It was hypothesized that by applying solution-focused techniques, unproductive behaviors would be halted and reversed.

Trianatafilou (1997) trained supervisors to implement solution-focused techniques using a four-step approach. First, supervisors learned to focus on supervisees' strengths. Next, the supervisor's aim was to identify "child-driven" solutions. Here goals were clarified, exceptions pointed out, solutions explored, and scaling implemented. The third element addressed the issue of feedback. Feedback from the supervisor to the supervisee was modified to systematically emphasize compliments, offer needed educational information, confirm therapeutic goals, as well as identifying residents' responsibilities. The final stage consisted of a follow-up session. At this point, the supervisor asked questions in order to encourage and enhance the supervisee's awareness of positive changes. The four-stage process integrated solution-focused techniques throughout the organizational structure, from supervisor to supervisee, and finally to the prime receiver, the children. Trianatafilou (1997) measured institutional change by surveying staff and by evaluating the amount of physical restraint and psychotropic medication used before and after implementing the solution-focused supervision techniques. As a result of this training, supervisors and staff perceived an overall improvement in supervision, and noted declines in the frequency of physical restraint and psychotropic medication (Trianatafilou, 1997).

Solution-Focused Case Management

Christensen et al. (1999) found that case managers are the primary point of contact between the individual and the service system that provides for their needs. Therefore, case managers play an important role in conveying empowerment. Unfortunately, the case managers' goals are often at odds with the viewpoints of the people whose needs they are meeting, and at times their perspective is completely discounted (Crane-Ross et al., 2000). Crane-Ross et al. established in their study that case managers thought people needed and received more assistance than people thought they needed and actually got. These discrepancies noted by Crane-Ross et al. (2000) may reflect a significant need for better methods by which case managers can understand individual's needs.

Christensen, et al. (1999) used solution-based techniques when working with families and found it helpful in partnering with them. Without this partnership, the resource managers were hampered in helping families understand what had taken place and in forming family-centered goals. An important step in solution-focused management is to help families become aware of possibilities by looking for their strengths and exceptions to their problems (De Jong & Berg, 2002). PsyR can develop plans that focus on solutions and convey hope and the expectation of recovery. These plans would incorporate solution-focused techniques to engage people and establish productive alliances and collaboration, which is the hallmark of PsyR.

Conclusion

Professionals in PsyR settings should give serious thought to assimilating solution-focused techniques into their treatment programs. The congruence between both schools of thought only hints at the potential benefit of a closer integration of these approaches: to strengthen the voice of the person in therapy in PsyR care and treatment. The literature in PsyR repeatedly stresses the need to promote a person-driven environment that advances the individual's needs. A solution-focused approach is a relatively new option that supports collaboration, and as such, it fosters greater input and direction from the person in therapy (or recovery). Although a solution-focused approach holds much promise for the field of psychiatric rehabilitation, more research is needed to better assess and understand the potential benefits of this approach.
References


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Recent innovations in the treatment of schizophrenia reflect a growing trend towards community-based care, such as Assertive Community Treatment (ACT). These programs reduce psychiatric hospitalization rates, improve residential stability, and result in improved satisfaction with care; however, they fail to show any consistent reduction in psychiatric symptoms or long-term improvement in social adjustment. As growing evidence suggests that the course and outcome of schizophrenia is significantly more favorable in undeveloped countries where community interventions are primary, this paper is an attempt to identify key factors in native African healing practices and their potential application to community-based treatment in the West.

Recent innovations in the treatment of severe mental disorders reflect a growing trend towards community-based psychiatric care. This trend began approximately 30 years ago with Stein and Test’s (1980) model of Assertive Community Treatment (ACT), a high-intensity form of case management that provides ongoing support and rehabilitation services within the community. The goals of the ACT model are to foster independent living skills and community reintegration for individuals diagnosed with severe mental disorders, especially schizophrenia. Services that may be offered include support and education around daily living skills (cooking, shopping, transportation), family education and counseling, vocational assistance, health promotion, medication support, housing assistance, financial assistance, assistance with entitlements (e.g., benefits services), relevant psychoeducation and psychosocial skills development, and problem-oriented counseling (Phillips et al., 2005). Furthermore, interventions and assistance are provided in the community, as opposed to being strictly office-based. Close variations and offshoots of ACT programs include the Program for Assertive Community Treatment (PACT), continuous treatment teams, and, within the Department of Veterans Affairs, Mental Health Intensive Case Management (MHICM).

Despite being only a recent innovation in the West, community-oriented models of treatment have been around for centuries in other parts of the world.