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Brief Solution Focused Therapy

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This paper introduces the development of, and the key assumptions and practices associated with, Brief Solution Focused Therapy (SFT). Therapist and client collaborate to clarify the best ways to build on existing strengths and resources in order to move toward a future that the client would prefer. The benefits of this approach for children, adolescents, their carers and teachers, are highlighted. Recent developments in the practice of SFT are outlined.

Keywords: Solutions; children; parents; collaborative

Introduction

When I first learnt about Solution Focused Therapy (SFT) part of its attraction was that elements of it were reassuringly familiar. It appeared to draw on some of my existing skills as a clinical psychologist, for example, skills in eliciting clear behavioural descriptions, highlighting strengths as well as needs, defining goals, considering the effects of change on significant others and asking clients scaling questions. I had the impression that learning more about SFT would be a matter of extending my current style of working. I now realise that my experience resembled that of clients encountering SFT for the first time and hearing, from their therapists, that they have evidently been doing some things right already, even though they are looking for further improvements. It is a tenet of SFT that clients possess talents and resources for resolving their difficulties and that it is the task of therapy to help them to build on existing partially successful attempts to reach a solution.

The development of SFT

Solution Focused Therapy, as pioneered by de Shazer and colleagues (1985, 1988, 1991, 1994), has its roots in Strategic Family Therapy, especially Brief Problem Focused Therapy devised by Weakland and colleagues (Weakland et al., 1974; Watzlawick, Weakland, & Fisch, 1974; Fisch, Weakland, & Segal, 1982). They had themselves been influenced by Bateson's (1972) approach to research in communication, Milton H. Erickson's unconventional approach to therapy, described by O'Hanlon (1987), and von Foerster's ideas about constructivism, summarised by Segal (1985).

Despite its historical connection with strategic approaches, SFT, and the related Solution Oriented (O'Hanlon & Weiner-Davis, 1988) and Possibilities (O'Hanlon, 1999) approaches, have moved away from some of the more ethically dubious techniques used by some strategic therapists, for example paradoxical interventions. The emphasis is on openness and collaboration between therapist and client. The approach now finds itself allied with other post modern collaborative approaches such as Narrative Therapy (White & Epston, 1990) and Just Therapy (Waldegrave, 1985).

A solution focused perspective is essentially interactional and useful not only for therapy but also for consultation, supervision and a variety of situations in which change is desired. It is possible to use the approach with individuals or groups. Many typical solution focused questions are phrased in a way designed to elicit information about interactions between key individuals. For example, 'What do you think your mother would like to get out of this meeting? What is she hoping you may get out of it, do you think?' 'How will her teacher know when she doesn't need any further help?' or 'What do you think your client would say had been helpful about the work you have been doing together?' Thus the solution focused practitioner gains an interactional perspective whether working with an individual child, parent, teacher, or colleague, meeting with a whole family or with members of a professional network. Clients find their concerns and wishes put into a context of their relationships with others.

Assumptions underlying the approach

George, Iveson and Ratner (2000) summarise assumptions it is helpful for solution focused therapists to hold:

- Attempting to understand the cause of a problem is not a necessary step toward its resolution;
- Successful therapy depends on knowing where the client wants to get to;
- However fixed the problem pattern seems to be, there are always times when the client is already doing some solution building;
- Problems do not represent underlying pathology or deficits;
- Sometimes only the smallest of changes is needed to set in motion a solution to the problem;
- It is the task of therapists to discover the ways in which clients are able to cooperate with therapy. The concept of resistance is considered unhelpful.

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The main elements of SFT

Clients are asked about any *pre-session change* to enable the therapist to begin a conversation about existing signs of solution building and to encourage clients to notice evidence that change is possible. For example, asking a mother 'What changes have there been in the time between receiving your appointment and bringing your son here today?' enabled her to share information about a meeting she had initiated with her son's teacher. The meeting had given the mother a clearer idea of the issues on which she and the teacher agreed concerning the boy's behaviour.

Problem free talk represents an opportunity for the therapist and client to converse about other aspects of the client's life, aside from the issue that has led to help being sought. The therapist explores the aspects of life that the client would wish to continue and develop regardless of the problem. It enables a better-rounded picture of clients and their situations to emerge.

SFT is goal directed at every stage. It is usual to inquire about a client's *goals for the session* by asking 'What do we need to talk over today to enable you to feel this meeting has been worthwhile?' Problems and their history are not explored in detail in SFT. However, *acknowledgement of problems* and of resulting distress is important for many clients. It may be vital in the process of building rapport and enabling the client to feel that the therapist, who will be focusing for much of the meeting on strengths and on goals, has really understood how serious the situation has been.

One of the key skills of SFT is asking questions to elicit examples of *exceptions* to the problem, that is times when a particular difficulty is less, absent or easier to cope with. For example:

'When did you last *manage* to get to school?'

'What's different about the times your child *does* listen to what you say?'

'When are the times it's *easier to resist the temptation* to lose your temper?'

'When did you last have a *holiday* from OCD?'

'When does the hyperactivity show itself *less* ?'

'What makes the sad feelings *easier to cope with* at times?'

The form of the question always implies that there will be an exception to be remembered, rather than asking *whether* there have been exceptions. The latter form of inquiry is more likely to produce a negative response from someone feeling overwhelmed by a problem.

To find out where the client wants to get to, the therapist needs to build up a picture of a *preferred future,* without the problem that has led them to seek help or to have help sought on their behalf. The *miracle question* was devised with this in mind. 'Suppose that tonight, while you are sleeping, a miracle happens and the problem that has been troubling you sorts itself out overnight… what would you see the next morning that would let you know the miracle had happened? What would you find yourself doing the day after the miracle, what would others notice you doing?' The question may be adapted for children or for any client for whom a 'miracle' might prove unsuitable. Another way to ask about a problem-free future is to say 'how would you describe yourself, at your best, on a really *good* day?'

Miracles are not always the well formed, realistic and concrete goals the therapist is aiming to identify, rather they point the way. *Scaling questions* provide a useful technique for moving from miracle to goal. For example, 'on a 0 to 10 scale, where 0 represents the worst things have been and 10 is after the miracle (or at your best on a really good day), where would you say you are today?' Scaling can be represented pictorially for children, for example using degrees of facial expressions from 'frowny' to 'smiley', or numbered stepping stones leading to the change wished for. When working with a family, a network of professionals or some other group, it is usually helpful to ask each participant for a rating. Differences between ratings should be explored as they often highlight important clues to maintaining and developing progress. For example, in a consultation with a family, each parent gave a different rating of their 10-year-old son's behaviour. The father's reason for giving a higher score, and the mother's for giving a lower score, were discussed. It emerged that the father had had the opportunity to observe the son making more of an effort. An exploration of the situation in which this had occurred helped the family to plan some ways to sustain progress, as well as letting the son know that his efforts had been appreciated.

It is unusual, although not unknown, for individuals to answer '0' to a rating question and so a further exploration of the path to a solution can be made. For example, if a parent replies '3' in relation to a child's sleep problems one may ask 'What got you from 0 to 3?… What would you need to go on doing to maintain things at 3?… What would you take as a sign that your rating had moved up the scale to 4?..What would you be doing then?… What would your child be doing?' Usually it is possible to observe, 'So there are times when it seems some of the miracle (or future you would prefer) has already happened'.

Toward the end of a meeting it is helpful, when possible, to take a break, for the therapist to collect his or her thoughts or to consult with colleagues if any have been present, before giving the client some feedback. This has several elements, of which *compliments,* about the client's strengths, resources, solution building activities and related personal qualities are highlighted. An attempt is made to acknowledge the problem in a non-blaming and non-pathologising way. Tasks may be given, usually in the form of a suggestion to notice what is already helping to move the client toward a solution, to carry on and to build on partial successes.

Subsequent sessions follow up what is working for the client, for example, what is helping the process of moving up the scale toward a preferred future. There is an emphasis on questions about exceptions, scales and coping.

SFT with children

A number of authors have focused on child clients or child and family issues. Berg (1991) and Berg and Kelly (1999) have used SFT in the context of services that have the aim of preventing family breakdown. Durrant (1995), Metcalf (1995), Murphy and Duncan (1997) and Rhodes and Ajmal (1995) describe taking the approach into schools. Selekman has used SFT with adolescents (1993) and children (1997). Metcalf (1997) has also

authored a self-help book for parents. There have been developments in the use of solution focused thinking and selected aspects of the approach in the area of Child Protection (Walsh, 1997; Berg & Kelly, 1999; Turnell & Edwards,1999).

Some features of SFT are particularly child friendly (Lethem, 1994). Children are frequently apprehensive about meetings that have arisen because of problems involving them. They may expect to be criticised or punished and be reluctant to say anything lest they draw unwanted attention to themselves. Parents and teachers may have reached a stage of blaming both the child and themselves for the difficulty, and may be unable to take a constructive approach without assistance. SFT's non-blaming attitude, together with problem free talk and exception gathering, serves to widen the perspective, reminding all concerned that there is more to the child, parents and teachers than the problem.

The language of SFT is concrete and relatively easy for even young children to grasp; therapists ask participants to clarify abstract concepts. For example, 'How would you like to see greater *respect* shown to you?' 'What counts as an example of *good attitude* ?' or 'What will greater *self-esteem* look like?' Solution focused therapists rarely ask 'Why' questions. Children usually cannot answer questions about the reasons for their actions and their failure to do so tends to be a source of frustration for concerned adults. SFT concentrates instead on the 'how, when, what and where' of solutions.

The approach utilises the imaginations of children, through the miracle question and other techniques for visualising the future. Rating scales can be transformed into stepping stones, rungs of a ladder or the distance from the bottom to the top of a hill, enabling individual work with children or their participation in family meetings. Their wishes for the future are respected, even when challenging the views of adults who have actively sought help. Questions like 'What would be going on in school when the teachers get off your case? What do you think they would need to see that would encourage them to back off?' or 'What will you be doing differently when your mum is no longer picking on you?' help to clarify, in concrete language, what it is that the child or young person wants. Ironically, the process of clarification often reveals wished for changes that the teacher or parent in the examples would also welcome, despite views of the problem differing markedly.

Outcome research

The concrete goals and rating scales of SFT lend themselves to outcome research and many of the centres of solution focused activity have followed up clients with positive results. For example, de Shazer (1991) presents the results of research carried out at the Brief Family Therapy Centre in Milwaukee, with 86% of those followed-up reporting good outcome at 18 month follow-up, after receiving an average of 4.6 sessions. Clients who came to more sessions reported better outcomes. Like many of the studies on SFT (Iveson, 1991; Macdonald, 1994, 1997; De Jong & Hopwood, 1996), it concerned adult clients and had no control group.

Zimmerman et al. (1996) randomly assigned parents of adolescents to either a control group or to a group receiving 6 sessions of SFT. Members of the latter group showed significantly better scores on the Parenting Skills Inventory. Similar results were obtained by Zimmerman, Prest and Wetzel (1997) in a comparable study of group SFT for couples. A comparison study of SF counselling groups and non-SF counselling groups for students found that those in the SF group did better, reporting 81% goal achievement. The counsellors themselves also appeared to benefit, with less exhaustion and depersonalisation being found in the SF counsellors at 1 year follow-up, compared with their non-SF counselling colleagues (LaFontain & Garner, 1996). Littrell, Malia and Vanderwood (1995) carried out a 6-week follow-up of three forms of single session brief counselling in a high school. Sixty-nine percent of all participants reported improvement, but the SF approach had involved shorter sessions. A 3-month follow-up of child mental health referrals that had received either SFT or routine intervention found that in the former, 68% reported improvement, compared with 44% of the comparison group. The individuals who received SFT also used fewer other clinic resources (Wheeler, 1995).

Two commonly asked questions in SFT workshops are 'Does it work?' and 'How *brief* is brief ?' While there are some encouraging reports (above) suggesting that SFT can be as effective or more effective than other successful interventions, and in fewer sessions, more research is definitely needed. Many of the existing reports may be viewed as audit and there is a need for more studies, including randomised allocation and appropriate comparison groups.

Current developments

The links between practitioners of SFT and practitioners of other collaborative therapies have resulted in some mutual borrowing of ideas and techniques. The influence of Narrative Therapy has led some SF therapists to externalise either the problem, or the solution, or both. Asking clients about the history of their wished for futures is another technique drawn from narrative approaches.

Early writing on the subject of SFT did not include specific reference to gender, culture, ethnicity, ability, sexuality or other differences of importance to clients. The general raising of awareness of issues of inequalities that has taken place in health, education and social services, together with the influence of Just Therapy, shows in the work of some practitioners. When finding a non-blaming, non-pathologising way of describing a client's predicament, it is not unusual to hear a SF therapist refer to the social disadvantages that may have contributed to distress and difficulties.

I have kept close links with the colleagues with whom I first learned about SFT. They are now based in the Brief Therapy Practice in London. From time to time we meet to discuss our work and the gradual changes in style and emphasis that have occurred over more than a decade of using the approach. While my main preoccupation, as a psychologist working in the NHS, has been to find ways of incorporating SF thinking in multidisciplinary team work, they have been interested in refinements of the approach toward greater minimalism (George, Iveson, & Ratner, 2001). They rarely devote time to exceptions in their conversations with clients

and have largely given up setting any form of task. The miracle questions remains in their repertoire but has become less central to the process than inquiring what a client's 'best hopes' are for each particular session and for the therapy as a whole. They find that the follow-up questions they ask in response to clients' replies to these questions usually clarify the clients' preferred futures, in a way that makes asking the miracle question unnecessary.

Conclusion

I opened this article remembering my early days as an enthusiastic novice of SFT, utilising my existing skills from cognitive behavioural therapy and family therapy. As de Shazer likes to point out, the approach is simple but not easy. What it offered me were some new ways to engage reluctant clients and to develop a more collaborative therapeutic style, in which clients' expert knowledge of their lives and aspirations meets my expertise in facilitating solution focused conversations. When working with children or young people accustomed to criticism, it has allowed me the pleasure of observing them hear something good about themselves, as their parents or teachers described the exceptions. It is an approach that can instill hope in clients and therapists alike and it deserves its reputation for countering the risk of burn out in its practitioners.

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