COVER SHEET

Rehabilitation Professionals and Solution-Focused Brief Therapy

Herbert C. Biggs
School of Psychology and Counselling, Queensland University of Technology, Australia

Ross A. Flett
School of Psychology, Massey University, New Zealand

Abstract

The rehabilitation professional is expected to be proficient in a wide range of skills and knowledgeable across several dimensions, not the least of which are the conceptual models and in many cases the processes of counselling itself (Biggs & Flett, 1995). There are many theoretical and practical models of counselling available, but I seek today to present a critical discussion of a relative new-comer to the realm of psychotherapeutics, Solution focused brief therapy (SFBT). It is not the purpose of this discourse to convince you that SFBT is the 'way to go' but rather to provide you with knowledge of a potentially useful tool that may be applied in everyday practice. To this end I will cover as best I can in the time allowed, the theoretical underpinnings of the 'solution-focus', the phenomenon of brief therapy, the techniques, effectiveness and limitations of SFBT, finally a consideration of the role of such an approach in rehabilitation settings.

Deriving a Solution Focused Theoretical Orientation

SFBT is based on constructivist epistemology – theory of knowledge that holds that the person cannot have knowledge that is objective or independent of themselves (Neimeyer, 1993). In essence constructivism asserts we construct our own realities and as such cannot hope to know a true universal reality. This is in stark contrast to Empiricism, which ascribes to a logical positivism that states, with sufficient observation and integration, we can know an objective and singular reality. Solution-focused therapy is borne out of this postmodern constructivist tradition. It allows the client the scope to be open to a multitude of possible realities. The reality that the client perceives is only one of many, and this is the key realization that facilitates change. One of the fundamental assumptions of the solution focused paradigm is that people are healthy and competent, and have the ability to reconstruct their lives. This is achieved by focusing on 'solutions' rather than 'problems'. As an alternative to delving into the complexities of personality and social interaction, or attempting to dissect the cognitive processes leading to distress, solution focused therapy emphasizes the search, not surprisingly, for solutions. For example, rather than attempting to uncover the reasons for an adolescent's illicit drug usage, the focus is shifted more towards how life could be without drugs and what changes could be made to facilitate such a transition. A true constructivist would avow that one should not even attempt to try and understand the causes of the client's problems. The solution-focused therapist's role is to open the client's eyes to a range of alternative existences. Thus, SFBT does not dwell on the problems and failings of the past. It rather seeks to harness the resources of the present and direct them towards achieving goals in the future. In effect the 'problems' are left behind.

Brief Therapies

One of the distinguishing features of all brief therapies is the deliberate use of time as an aspect of the service contract between interacting participants. In this instance therapy is brief by design (Kadushin, 1998), in contrast with what Bloom (1992) has referred to as unplanned short term therapy. Once viewed as a superficial and expedient treatment to be used only in emergency situations (e.g. crisis management) until long term therapy could begin, brief therapy is now considered as the most appropriate treatment for a substantial number of clients (Koss & Shiang, 1994). In a recent Delphi Poll of 62 distinguished mental health professionals (all held doctorates and averaged 30 years of post-doctoral clinical experience) the transition to brief therapy was rated the largest therapy format transformation expected in counselling practice (Prochaska & Norcross, 2003). In Kadushin's (1998) view three factors have contributed to this shift from long-term to short-term treatment. First, the impact of managed care and its derivatives on service delivery patterns. Second, the ongoing budgetary constraints in the welfare and social services sector. And finally, growing evidence that brief therapy is the treatment of choice for certain specific problems. While managed care is not strictly the model in Australia, the mounting pressures for social services to do more with less, and to manage problems not only effectively, but efficiently, heralds a system increasingly similar to managed care.

For correspondence concerning this paper contact: Dr Herbert Biggs, School of Psychology and Counselling, Queensland University of Technology, Beams Road, Carseldine, QLD Australia 4034. Ph: +61 7 38644722, Fax: +61 7 38644660, email: h.biggs@qut.edu.au

Whilst brief therapy may appear to be a contemporary phenomenon, the reality is that brief therapy has been researched and applied for over 50 years. In essence brief therapy has not been discovered, but rather rediscovered. Many forms of psychotherapy hail a short-term or brief format, and in some cases the approach used, like SFBT, facilitates a constructive use of time; for example gestalt therapy, cognitive therapies, exposure/flooding therapy, and systemic therapy. Given the wide variety of therapeutic approaches and the antithetical contrasts seen when comparing some therapies, it is no great surprise that there is no unified theory of brief therapy. Indeed, O'Hanlon (1990) argues that the move to more eclectic practice denies the need for such convergence.

The Focus of SFBT

Irrespective of the substrates of the various models of brief therapy, efforts are predominantly focused on a problem or solution. Commentators also address the sometimes subtle, sometimes not, distinction between "problem" and "solution". De Shazar (1991) has moved to strike the notion of problem as a useful one in therapeutic discourse. Noting that the word problem also implies a non-problem, de Shazar emphasize's that the space between a problem/non-problem is also available to the client and therapist for use in constructing a solution. The process of 'solution talk', as opposed to 'problem talk', was originally developed by Insoo Kim Berg in the mid-1980s at the Brief Family Therapy Center in Milwaukee, Wisconsin. While the initial focus of the therapy was on problem drinking, the principles and practices of SFBT have made it an increasingly popular form of therapy, rated amongst the top 10 therapies to continue to grow in the future by the Delphi poll mentioned earlier. As the name implies, SFBT is indeed a form of brief therapy. A study of 275 clients presenting for therapy at the Brief Family Therapy Center in Milwaukee indicated that more than 80% required 4 or fewer sessions, with an average of 2.9 sessions (DeJong & Hopwood, 1996). Despite its family oriented beginnings, SFBT has been applied successfully as individual therapy in the treatment of adjustment disorders (Aranoz & Carrese, 1996), deviant youth behavior (Simon & Berg, 2002; Wilmshurst, 2002; Young & Holdore, 2003) and has even been recommended for chronic psychiatric patients (Booker & Blymyer, 1994; Webster, Vaughan, & Martinez, 1994), cancer patients and their families (Neilson-Clayton & Brownlee, 2002), and used in conjunction with psychopharmacologic intervention (Trautman, 2000).

The Techniques of SFBT

Exceptions. In searching for a solution to the identified problem, clients are encouraged to seek exceptions in their life where the problem is not salient. Using this technique the client is guided to recall instances where the problem does not exist. And thus in a process of social deconstruction, the client and therapist talk about exceptions to the problem. Problems are de-emphasized and deconstructed, and in a parallel process the evolution of solution construction begins. This deliberate de-emphasis of problems and amplification of small exceptions can and has attracted criticism that solutions may be generated from seemingly random and unrelated shifts in concepts or action without full understanding of the problem patterns. Yet, the active therapist is focused on using the exceptions as only examples of life without the problem, and using these instances as resources for constructing solutions. This combined with the adherence to goals and tasks defined earlier keeps each session focused. Clients are encouraged to predict when they are likely to overcome problems and then asked to account for the accuracy of their prediction. A focus on predicting exceptions is believed to increase the frequency of such predictions. The more often exceptions are noted the more distant the problem is said to become, and as such a self-fulfilling prophecy emerges.

Miracle question. In the absence of exceptions, as some clients may not be able to find relief from their problems, clients are asked the "miracle" question (DeJong & Berg, 1998; de Shazar, 1988). Here the client may be asked a question such as "Imagine you woke up and by some miracle your problems were gone. What would be different?" Through exploration of the client's responses a sense of life without the problem may be considered and then used as a benchmark for the setting of tasks and goals (Berg & Dolan, 2001). This approach was derived from Erickson's "crystal ball" technique.

Scaling question. Clients are asked to rate on a ten-point scale how things are today. For example: "On a scale of 1 to 10, where 10 is 'the problems for which you came to therapy are now solved' and 1 is 'the problems are the worst they have been,' clients rate where are they now on that scale. Using this technique the client continually evaluates their progress, and this information also serves as a form of feedback. This scale has been used in outcome research as a measure of therapy effectiveness, where traditionally moderate progress is an increase of 1-3 points and anything above is considered significant progress (DeJong & Hopwood, 1996). While the subjective nature of this approach is consistent with the constructivist ideal, greater understanding of the effectiveness using more objective measures has been suggested (Gingerich & Eisengart, 2000).

Consulting break. Towards the end of the session a short break is taken. This has been an important ritual in family therapy in general and in Solution-Focused Therapy in particular. Among its therapeutic advantages, it: (1) affords therapists the opportunity to consult with colleagues on their team; (2) gives the therapist time to prepare constructive feedback for the client(s) and compliments for what they are currently doing that works; and (3) allows time to devise helpful therapeutic tasks (Sharry, Madden, Darmody, & Miller, 2001). Sharry and

colleagues suggest that this process may be augmented by the use of a more "client-directed" session break, whereby clients are encouraged to use the break to reflect on what has happened in the session, to generate their own conclusions, and even to assign themselves homework if they wish.

These techniques are fundamental to SFBT, and are readily seen to reflect the constructivist position through aiding in the search for a solution or different reality. Furthermore, the basic assumption of human competency serves to identify the "strengths perspective" (Saleeby, 1992). Under this perspective, every individual has a range of resources that may mobilize to assist in the formulation and action of seeking a solution. Accordingly, a focus on abilities and strengths de-emphasizes a 'blame the victim approach'. These assumptions are grounded in the post-structural notion that the client's meaning must count for more in the helping process, and scientific labels and theories count for less.

Therapist Requirements

The solution-focused therapist must play an active but empathic role to assist the client in looking beyond past and present problems, to identify goals, and to foster and build on the client's current resources. In this way the client remains in control of their destiny. The therapist's role is to stimulate and encourage to desire to change through allowing the client to see how their life can be different. A natural corollary of this is that each solution will be unique to the individual, and that the client and therapist act together to form the goals needed to reach solutions. This relative equality of roles in the therapeutic relationship empowers the client to take responsibility and action (Hoyt, 2000). Unsurprisingly, very little time is spent on aetiology, diagnosis, or problems. The essentials of SFBT are to capitalize on current strengths, emphasize activities independent of the problem, speak of solutions, and importantly to commence or accelerate the process of change. This last point is crucial in that the client is empowered to see what they can achieve and to continue to work at these goals long after therapy has formally ceased.

As is the case with all forms of psychotherapy the counsellor's attitude towards its effectiveness is vital. There are many examples within the literature where the orientation of the therapist has a significant bearing on the success of the intervention (Prochaska & Norcross, 2003). Pinkerton (1996) has suggested that the following attitudes and skills are required for brief therapy to be effective:

- Belief in the therapy's effectiveness
- Comfort with a position of authority
- Comfort with modest goals
- Ability to come to a rapid and accurate assessment
- Ability to establish a positive relationship rapidly

In addition to this the therapist needs to have sufficient flexibility to adapt to the client's reality and desired reality and a capacity to try new or creative approaches to help client's find solutions. In essence, the counsellor must be a lateral and creative thinker if unique, meaningful, and tangible goals are to be set and met. The importance of goal setting in this format of therapy cannot be overstated.

Setting of Goals

Although it is true of all modern therapy modalities, goal formulation is paramount to the success of finding solutions under time-constraints. To this end leading advocates of SFBT have proposed the following criteria for developing goals (Berg & Miller, 1992; Walter & Peller, 1992):

- Positive: focus is directed to activities other than the problem. So rather than trying to be rid of the problem, the counsellor may ask, "What will you be doing *differently*?"
- Process: goals must be concrete and behavioural. This allows the client and therapist see how the goals will be reached and when they reached.
- Present: efforts are directed towards keeping the client on task, not to be dissuaded by the past or distracted by the future. What can they do right now?
- Practical: this is more than simply setting realistic goals. At each point the goals should be small enough to be attainable, meaningful enough to be significant, and focused enough to lead to a solution. Naturally goals must be revised constantly.
- Specific: as much as possible goals should direct specific actions (when, where, how) as opposed to the stating of goals.
- Client-control: emphasis is placed on what the client is doing so that they own their solutions. The goals should be attainable but must be seen as hard work. This acknowledges the difficulty in effecting change and supports a sense of self-worth on reaching the goal.
- Client-language: allow the client's description of their situation guide the formulation of goals. This will help make the goals relevant and important to the client.

The goals selected should help the client to see exceptions to their problem. As mentioned, SFBT openly seeks to capitalize on an individual's current strengths. Therapeutically this entails selecting strategies the client uses that work for the client and seek to augment them. And, as suggested by the miracle question, if nothing

appears to work initially, a more creative or experimental approach may work. Importantly, the goal must actionable immediately, thus maintaining client motivation and direction. DeShazer (1994) has several suggestions for constructing solutions:

- Ask the client what their goal in coming is, rather than why they are there
- Acknowledge problems with sensitivity, but be prepared to shift the focus to solutions
- Encourage change from the outset
- Use clients' resources through noted exceptions
- Attempt to determine to what extent exceptions are under the control of the individual, and how they may become more so

Effectiveness of SFBT

Strictly speaking a constructivist is not concerned about justifying their practice through 'scientific' methods. SFBT seeks to help the client see their reality in a different way. This is at odds with the reductionist positivist tradition, which demands large-scale standardized treatment and measurement. Nonetheless, a few outcome studies have been published. Early outcome studies reported the effectiveness of SFBT, yet their lack of objective measurement and experimental control made them impossible to interpret (DeJong & Hopwood, 1996; Shazer et al., 1986). Gingerich and Eisengart (2000) reviewed 15 outcome studies of SFBT, separating the studies as well, moderately, and poorly controlled. The studies were identified through using key terms: "solution-focused" OR "solution-oriented" AND "outcome" in literature databases and studies thus found were critiqued using the standards developed by the American Psychological Association (Task Force on Promotion and Dissemination of Psychological Procedures, 1995) and modified by Chambless and Hollon (1996). These standards require

1. Use of a randomized group design or acceptable single-case design;
2. Focus on a specific, well-defined disorder;
3. Compare the experimental treatment with a standard reference treatment, a placebo, or less desirably, no treatment;
4. Use of treatment manuals and procedures for monitoring treatment adherence;
5. Use of outcome measures with demonstrated reliability and validity; and
6. Use of a sample large enough to detect group differences reliably.

Five studies (N = 40 to 59) that were well controlled (meeting 5-6 standards) all demonstrated positive outcomes – four found SFBT to be better than no treatment or standard institutional services, and one found SFBT to be superior to a known intervention, Interpersonal Psychotherapy for depression. These studies covered depression in a university clinic (Sundstrom, 1993), parent-child conflict in a university clinic (Zimmerman et al., 1996), orthopedic rehabilitation (Cockburn et al., 1997), recidivism in prisons (Lindforss et al., 1997) and adolescent offenders in secure custody (Seagram, 1997). Therapy lasted from 1 to 12 sessions and follow-up ranged from none to 12 months across studies and included individual and group formats.

Four studies were moderately controlled meeting 4 standards, and the remaining six studies were poorly controlled meeting 3 or fewer standards. Having said this, the non-well controlled studies generally produced results consistent with the hypothesis of SFBT effectiveness (Gingerich & Eisengart, 2000).

The principal author and a colleague replicated the search strategies of Gingerich and Eisengart for articles published from 2000 to the present and found only one controlled and two uncontrolled additional studies. In the controlled study, the method of delivery of services to troubled adolescents (Home vs Residential-unit) was confounded with therapy (Cognitive-behavioral vs SFBT) making treatment efficacy impossible to disentangle (Wilmshurst, 2002). The two uncontrolled studies in adolescents with mental health problems (Wheeler, 2001) and troubled families (Beyebach et al., 2000) found results in favour of the effectiveness of SFBT.

This collection of studies however provides preliminary evidence in favour of the effectiveness of SFBT in a range of settings. Obviously, more work is required to determine the full range of settings in which SFBT may be considered appropriate and in particular, efforts should be afforded to undertake head-to-head comparisons against rival popular brief therapies (e.g. Cognitive-behavioural therapy). Many consider that there is inadequate SFBT outcome research, and claims that it is the briefest of brief therapies are unfounded (Stalker, Levene, & Coady, 1999). Despite the rejection of the scientific method by purist constructivism, the case for recognition for a relatively fledgling therapy such as SFBT would not be harmed by the pursuit of evidence of effectiveness and efficacy given the present legal and bureaucratic atmosphere.

Limitations of Brief Therapy

It should be no surprise that not everyone is enamoured with brief therapies. There are of course entire theoretical orientations that do not believe in an active and time-limited approach to therapy (e.g. existential therapy, person-centered therapy). Stalker and colleagues (1999) remind us the there are some apparent 'truths' regarding psychotherapy inasmuch as: (1) psychotherapies in general have positive effects when compared to no treatment; (2) psychotherapies do not differ in terms of their effectiveness, apart from a few exceptions (CBT

with panic and phobias); and (3) the quality of the therapeutic alliance or relationship with regards to warmth, acceptance, empathy, respect and collaboration is crucial to therapeutic outcome. To balance the discussion and before wholesale embarkation on the indiscriminate use of brief therapy, it would be wise to recall the five **myths** of brief therapy noted by Gelso (1992), which remain as relevant today as in 1992:

- Brief therapy is as effective as, or more effective, than long-term therapy
- Changes in brief therapy are highly durable, as durable as those in long-term therapy
- Because most measurable change occurs during the first few sessions, a few sessions of therapy are all that is needed
- Therapist-perceived lack of efficacy about brief therapy is a perceptual error, whereas other rating sources see the true value of brief therapy
- Abbreviating interventions through establishing duration limits inevitably saves agency time

The objective of SFBT to move the client from problem to solution rapidly may not rest easily with some clients. This may not simply be a matter of skill on behalf of the counselor who will have a mind set and assumption that client's want to change, have the ability to perceive change, and will make their best effort to effect change. The client for multitude of reasons may simply not be ready for these actions and the therapy if applied will be both ineffective and inappropriate.

Moreover, some have argued that brief therapy could do more harm than good if inappropriately applied (Cooper & Archer, 1999). Koss and Shiang (1994) suggest brief therapy of any mode is less effective for clients with psychosis, or with personality and substance abuse disorders. If the client's needs are not adequately assessed, not only will the problem persist, but a resistance to therapy may develop. And this taste of therapeutic failure (as opposed to client failure) may serve to undermine any future therapeutic alliance. This is of particular concern given the singular importance of the therapist-client relationship to successful outcome (Lambert & Bergin, 1994). Stalker and colleagues (1999) have also been justifiably critical of the seeming neglect of SFBT to the other 'systems' involved in a person's problems, whether they be genetic or biological, or dependent on the legal or medical system. They also express concern over the apparent 'blind' adoption of solution-focused techniques in some circles, seemingly denying the mandate that no one therapy will solve all problems. We are further reminded that to neglect the wider issues of investigating the problem thoroughly and taking sufficiently detailed assessments is a disservice to the client, and unprofessional. Nyland and Corsiglia (1994) have warned against the ease with which a counsellor can become 'solution-forced' and 'problem-phobic'. In this vein, restraint and calculated application of brief therapy - including SFBT - is required in all situations (Gilbert, 1996 and it is prudent to consider a more eclectic approach when needed

SFBT in Rehabilitation Environments

Notwithstanding these cautionary comments, SFBT has a valuable role to play in rehabilitation settings. In considering the role of Brief therapy in rehabilitation counselling interactions, Schultz and Ososkie (1999) discuss three components that they believe are common to most forms of brief therapy in the rehabilitation environment.

(a) The selected focus is problem specific – It is argued the specific diagnosis (in the context of psychopathology) is not required and that the focus should be on improving client functioning (Anthony, Cohen, & Farkas, 1990). Brief therapy must be focused and goal-oriented to succeed (Quick, 1996).

(b) Time limits must be applied – while there is little agreement on the number of sessions, ranging from 1 to 72, it is essential that constraints be placed on time in order to focus both the counsellor and client on achieving goals. While longer-term interaction and follow-up will be required in the setting of rehabilitation counselling, there is still the opportunity to focus efforts on specific problems at specific times. In the context of larger and ongoing problems it may be worthwhile approaching management with serial use of brief therapies where appropriate.

(c) Performance of therapeutic tasks – this hinges on the early identification of goals to guide rehabilitation. It requires the client to be active in their therapy, and thus helps them take responsibility and instils confidence with the achievement of set goals.

In addition to this Kadushin (1998) has suggested:

- Expeditious development of a positive relationship or working alliance with the client – the counsellor must create a trusting and safe environment for the client by providing hope, acceptance, support and confidence. This allows the rapid development of appropriate tasks and goals, and provides structure and focus to each interaction.
- High level of counsellor activity – to keep up with the demands of economical, time-limited therapy, the counsellor must be willing and competently employ methods of confrontation and interpretation, and be willing to make suggestions. The client is often given 'homework' tasks. 'Take-away' therapy is an important aspect of many modalities of therapy, but its significance is highlighted in the brief format.

There seems little disagreement that counselling as a competency us an integral component of the skills base of the rehabilitation counselors and an important cross-disciplinary acceptance of the utility of counseling in rehabilitation settings (Biggs and Flett, 1995). More recently there has been increased emphasis on enabling rehabilitation counselling activities in tighter and tighter fiscal environments. This has seen the emergence of models of disability management and managed care where closer contractual partnerships between all parties are the norm.

This rapidly changing, and now durably emerging environment, has required substantial change in the skills base of all rehabilitation professionals.

Contemporary rehabilitation management processes, particularly in accident insurance environments, has emphasized efficient process values through case management and disability management. These efficiencies have impacted negatively on access to many traditional counselling techniques which may have relied on longer term, developmental substrates for their success. The main efficiency driver has been the imposition of resource accountability, and this includes the quantum of time available for the delivery of services, especially that of the counselling therapeutic process itself.

Solution focused brief therapy techniques represent a conceptual and practice model that appeals to funders of the rehabilitation process. They may also meets with approval from a large body of providers and a significant number of clients. The techniques however are not the universal panacea and it remains important for all parties to advance research into the effectiveness of these therapies, support their use where appropriate, and more importantly support and resource the use of alternative techniques when SFBT is inappropriate. I am certain that brief therapy will continue to assist many of our clients into the future, and I am pleased today to have had the opportunity of addressing this topical and interesting development.

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