

Solution News

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It's not often that any of us get to meet with our heroes, never mind interview them. It was attending a workshop by Bill O'Hanlon that first set me on the solution oriented path, and whilst I have since come to appreciate the work of many other thinkers and therapists, it is still Bill's style and approach that has inspired me most, and probably Bill's fault (lawsuit pending) that over the last few years I have moved home and jobs (and even gone back to college) to find ways to make my own practice more helpful and respectful. So as you can guess I was thrilled to be able to ask him about things I've always wanted to know his thoughts on. A special thanks to Bill for being so willing to take part.

There are also two big developments happening for *Solution News* to tell you about. Firstly our long-awaited 'solution focused peer review' system is now up and running. This is not your run-of-the-mill hurdle-to-be-leaped, but a chance for anyone who was even vaguely thinking about writing an article to get a bunch of helpful feedback and encouragement from published authors! We've developed some guidance for authors that explains all about the system. You can find them soon on our web-site, or email me (editor@solution-news.co.uk) and I'll send you a copy.

The other big development is that the few sorry-looking mp3 files we had on the web-site have now morphed into SOLUTION NEWS RADIO, an internet broadcast ('podcast') that you can get from our web-site or subscribe to through the itunes store. Upcoming episodes will feature reports from conferences and interviews (including audio from the Bill O'Hanlon interview). We also want you to send us audio to include in the shows - just email radio@solution-news.co.uk.

Right, that should keep you all busy! Enjoy!

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In Conversation with Bill O'Hanlon

Bill talks to Solution News about therapy, (non) pathology, and how to make the world a better place.

Ian: What do you think distinguishes the way you practice from other solution focused approaches?

Bill: Well, hopefully I had a little influence on the solution focused folks, but I think the initial differences (I think there is a little less difference these days) is that my approach is less formulaic. When I wrote the book with Michelle Weiner-Davis (who had studied up in Milwaukee with Steve de Shazer and Insoo Berg and their group), she wanted to put flowcharts in the book that we wrote together. Flow-charts? That is something for engineers! I do therapy with my heart, and my intuition, and my guts. I don't do therapy with my head or flowcharts or decision trees. I don't do any of that stuff. Every session is different for me. I think I have more of that Erikson influence, who individualised treatment so much.

I do think there is a value to having the questions, and the techniques, and the structure of a session, because it is easier to learn it. But when you learned from Eriksson it is almost impossible to learn this way because he didn't structure it at all. I think through my books I've tried to provide some sort of guideline and structure,

but it's less formulaic [than the Milwaukee model], less structured. It's more about connection than it is about technique, and more about a certain attitude. That is why I call it solution ORIENTED rather than solution FOCUSED. I'm not focused on solution, but I'm oriented in that direction. Away from pathology, away from diagnosis, away from fixed labels, and towards strengths, resources, abilities, confidence, all that stuff, but it is an orientation rather than a focus, so I think the names do reflect some of this.

Second thing: somebody else told me this. He said that he and

his team had just learned solution focused, were just getting into it and you think "this is the greatest approach!", and then they kind of got to a more balanced place, but then they had a new person come on their team, and that person would become on fire with the approach and think "this is the greatest approach", but then they would go and kind of force it on their clients. They'd say "what is better this week?" and the client would say "nothing's better" and they'd say "what? On a scale of one to ten..." you know, and they would just fall back on the techniques and they would stop listening to the person and connecting with

"Flow charts? That's something for engineers!"



Bill O'Hanlon needs no introduction. He was Milton Erickson's only work / study student, and is the creator of solution-oriented, possibility and inclusive therapies. He conducts workshops on therapy, hypnosis, training and spirituality world-wide, and can be reached at www.brieftherapy.com.


In Conversation with Bill O'Hanlon

them, because they were so excited about using the technique. And behind the one way mirror they would be watching and see more and more of a misconnection and then they started joking behind the mirror, "this is solution 'forced' therapy". I know Insoo and Steve have said that "that's just bad solution focused therapy". Well, it may be bad solution focused therapy, but it's done a lot that way. When people get into the formula of it, they sort of forget that the connection needs to be there, so I think that's the second part of what I think was missing in the initial description of the solution focused approach, and hopefully was in the solution oriented approach and some other approaches, is that sort of Carl Rogers of listening, and connecting, and acknowledging problems, feelings and suffering a lot more. Now, I know that that was DONE a bit in the solution focused approach, but it wasn't WRITTEN ABOUT at all [in the solution focused literature], whereas I'd been doing that, until Eve Lipchick came along and actually wrote about it formally, about the use of emotions in solution focused therapy. Emotions, that was an important thing. I think that was the second difference.

The third thing is I was a hippie, and interested in social justice issues, and when narrative therapy came along I thought that we don't take it up so much in solution based therapies, the social justice stuff, we don't take up oppression issues very much, and so the wider social context sometimes gets lost in the wonderful minimalism that I think, especially Steve de Shazer, had. One of his brilliances I think was this idea of "don't get distracted by all this other stuff". It's very simple and I really appreciate the Zen simplicity of de Shazer. But that isn't appropriate in all cases. I think that social justice, social concerns, the oppressive aspect... the United States tends to be oblivious about social issues, starting with George Bush on down, and we don't really recognised that kind of social oppression so much, but in Britain and in other countries,

I think there is a lot more political and social awareness of these issues and I think that that got dropped out of the [solution focused] model.

Having said this, through the years people have said to me "you're a solution focused therapist", and I bristle and say, "no, I'm not a solution focused therapist. I never studied in Milwaukee. I have nothing to do with them. I'm solution oriented". But most therapists don't make these subtle distinctions. It was really Steve de Shazer, Insoo Berg and myself, and a few other people - we're arguing over split hairs. We are generally in the same ball park, in the same territory, we are hopefully on the side of the angels, in that we are non pathologically-based, we are resource oriented and solution based and we are in contrast to a good percentage of other therapists who take an expert stance and say "we know what the nature of your problem is and we know what the nature of the solution is for everybody - it's always a cognitive change, it's always your childhood trauma, it's always connecting with your feelings". These approaches have a pathological and expert sort of orientation. And based on that, we are more alike than we are different, I'd say.



"We are hopefully on the side of the angels"

Ian: I've met a lot of psychodynamic therapists who have encountered solution oriented thinking and taken it on and then tried to find ways to integrate the two in one way or another. In some of your recent writing I know you've mentioned that your inclusive therapy is influenced by psychodynamic thinking. I guess I'm curious about which bits of dynamic theory you include and which bits you still think aren't very helpful?

Bill: Well, the first thing is I know a lot of people have psychodynamic or analytic training because it is very popular approach all over the world. I wasn't really trained in that. I came up through the kind of

In Conversation with Bill O'Hanlon

interactional, behavioural (not so much cognitive), but more strategic, family therapies. You know, non-pathology approaches for the most part.

But one of the bits [of psychodynamic thinking that I find useful] is that people DO have bigger and life-long patterns and psychodynamic therapies take a look at this. I also think that trauma is important. I know this is something Steve de Shazer and I disagreed about. I used to teach workshops on solution oriented approaches for resolving trauma and he, when we met at a conference, he said "Why are you teaching these workshops? You are orienting to the person's diagnosis and the problem, rather than..." And I said "well that's how most of the field thinks about it. They think of people who've been sexually abused and traumatised and I want to bring them along to this orientation, but I actually do think that trauma and life long patterns are relevant things".

I think the only other thing that I like about the pure analytic therapies, which generally I don't have much truck with, is that in the best of psycho-dynamic and psychoanalytic therapy there's this open space where the client or the patient can say anything, feel anything and is seen and experienced and brought in non-judgementally. There's this space, a real space, rather than "you can only talk about solutions", or "you can only talk about what you did this week", or "scale these things". Again, it's the opposite of formulaic, and I kind of like that aspect. And so, from Erikson's work I got this very permissive, inclusive approach that he used sort of as a manipulative technique, if you will, to get people into trance or to get them to co-operate with treatment. But I saw and started to experience it as a more healing modality, that you can create this open space for just validating people, listening to people and bringing in the complexity that they bring in from their lives to therapy, and I find that to be a significant expansion to the

solution based approach. So, I am excited about that, but generally psycho-dynamic stuff that relies on insight and that has a pathological and early-childhood-origin theory of problems, is not that interesting to me.

Ian: How about ideas of transference and counter-transference that describe what's going on in the room?

Bill: Well, again, I've experienced that certainly, but not too much. I think, number one, in briefer therapies that doesn't arise so much. But in life it does, occasionally. So occasionally I've met someone I had an instant either dislike or attraction to or I was finding myself doing things that I never did in therapy. Letting the client not pay the bill or something, you know some really strange things. So I think that does exist. I just don't think it is typically so relevant to resolving the therapeutic issues except (and here is where we are getting into inclusive therapy), except when it is.

That is, I've had a few cases, even though, I haven't been trained very well in this awareness of transference and counter-transference and how to work with it, and the kind of methods I have don't really speak to it or have a procedure for it, but just in the human relationship I've noticed, gee, I think that's a transference or counter-transference situation. The person's projecting on me or reacting to me like I'm somebody else, like

the significant person from their life. Or I am reacting to them as if they are somebody else, and so I think it is OCCASIONALLY relevant for someone who does this kind of therapy or briefer therapies, but VERY occasionally, and it probably is a good idea to get some training in dealing with it. But I can count in one hand or maybe two hands the cases in which any of those dynamics

have been relevant to the treatment part or they interfered with or I needed to deal with it in some ways.

"I can count on two hands the times that counter/transference dynamics have been relevant to treatment"

In Conversation with Bill O'Hanlon

Ian: One of the big discussion issues in the UK recently has been about differences between the way solution focused therapists work over here and in Europe, and how solution focused therapists work in the States. As someone who does workshops in both places frequently, what is your impression? Have you noticed any differences in the way things are done between here and there?

Bill: I haven't so much. I think again it is more of a personality style and I think that in Europe the biggest influence has been Steve de Shazer and perhaps Insoo, but especially Steve. He's had a great influence in Europe and less of an influence in the United States.

Steve was a strange fellow in terms of how he interacted socially and how he taught, and that style didn't work so well in the States. People found it off-putting because he didn't answer questions very much, or he dismissed the questions, or he was a little gruff. So after a number of years he just started teaching in Europe and Asia. My explanation was, [that in Europe and Asia] they just thought he was a strange American and decided just to put up with it, or maybe Europe and Asia have a lot more tolerance for that kind of stuff. But in America, people thought he was off-putting and weird and so I think he's had a lot more influence over here with that 'pure' brand [of SFBT].

And I also think that Europe (partly because of the European Brief Therapy Association) took up research more than the States did. There wasn't much research done in the States. There was a little and there is a little, but not too much. But I think there was a great concerted effort [in Europe] to make this a legitimate approach to therapy.

And in America it got associated in some ways with saving money, because it became taken up by the insurance companies and managed-care companies who [had] started to restrict treatment as a way to save money. [Then they thought] rather than restrict

treatment, if we do this approach [solution focused therapy], the treatment will naturally be less expensive, we won't be keeping people in therapy for years. But it became a forced approach - "let's make therapy a lot cheaper because we can make it shorter". And it got a little tainted, I think, by that. Brief therapy was seen as this cost-cutting measure, rather than an exciting philosophy that kind of empowers people, and I was sorry to see that happen.

Otherwise, I don't see too many differences. But like any movement, I assume that as we get further from the founders, that the actual practitioners will start to find new ways to do, think about and describe it rather than slavishly following the founders who had their own biases and limitations.

Ian: Do you think the therapy itself might need adapting for working in different cultures?

Bill: You know, I sort of didn't answer your last question, I guess in a certain way. But as I travel around the world,

I find the problems and the solutions are more similar than they are different. Obviously there are cultural conditions, and cultural differences, but I find I do therapy wherever I go. In China, Japan, I do demonstrations, I sometimes do consultations, I sometimes do therapy. I've done it in

South America, I've done it in all over the United States, all over Europe, in Australia, New Zealand. I find more similarities than differences, so I think the local therapists will find a way to change it a little, but it seems to me more universal than it does needing so much adaptation. I think each client is a cross-cultural experience, in that each client has their own little culture, each family, each couple or each group. And so you will always have to adapt a little to adopt the local customs. But, otherwise, I don't think it's that necessary to make a lot of changes, at least in my experience.

"Working with each client is a cross-cultural experience"

In Conversation with Bill O'Hanlon

Ian: Ok. So, we have Solution Oriented Therapy, Possibility Therapy, Inclusive Therapy... what's going to happen next?

Bill: Well, I never wanted to get caught in a particular label so I kept thinking of new ones... and also because solution oriented kept getting confused with solution focused, I decided, ok, possibility therapies then, and then I came over this inclusive therapy and then I thought "that is a little beyond possibility therapy" so I liked that.

I obviously have a great interest in spirituality, and I have a simple and clear definition of a sort of solution-oriented spirituality. I have a great interest in personal development and I decided that... I've made a lot of contributions to therapy and have written a bunch of books. Occasionally, I still have something new I want to say [about therapy], but mostly I've said what I wanted to say.

So, I think I still have some contributions to make to therapist development and general people development, and to bringing

this solution oriented and possibility and inclusive attitude to how you define what you are supposed to do, how you make the contributions that you need to make in this life. How do you move the barriers or the fears that you have, or the restrictions that you've had, so that you can go on and make a contribution so we can make this a better place and have better leaders than we have now and less war and less suffering. So that's my new mission. I had an old mission to change psychotherapy because I was quite upset how it's mostly practiced in our field. I thought was a dis-service to clients and not very effective and I still have that mission, but I have a bigger mission to help people figure out what they are supposed to do in life and go and do it.

Listen to Bill's answers to more questions (including what Bill sees as his most important message) on Solution News Radio over the next few weeks!

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Solution Focused Asperger Syndrome

The Service User's Expertise: Experience into Practice

Genevieve Edmonds and Vicky Bliss describe their fruitful therapeutic encounter with each other



Genevieve is a 24 year old service user/survivor with diagnoses of mild Asperger Syndrome, depression and anxiety. She works UK-wide in the field of Asperger Syndrome, autism and mental health giving training, workshops, talks and general peer-support and advice. She is the author of *The Asperger Guides* (Sage/ Paul Chapman Publishing) self-help guides. Genevieve is part of Missing Link Support Services (www.missinglinksupportservice.co.uk), who support individuals 'disabled by society' using solution focused approaches.

As a somewhat tired and cynical individual who by her early twenties had received a myriad of therapies including talking therapies for anxiety and depression, and later a diagnosis of mild Asperger Syndrome, I wasn't really interested in seeing yet another well-meaning 'therapist'. Even less was I interested in meeting one with a name like 'Vicky Bliss'! For me it conjured up images of a 'perfect' psychologist-type dressed in immaculate clothes and shoes, who had that tone of voice that was perhaps a little too soft and sympathetic, who was perma-happy and who never got depressed herself. Worst of all I imagined someone who felt she had all the answers and the knowledge of how to fix me, after all she was the 'expert professional'! I was there to be fixed and changed wasn't I? If I was such an expert in fixing myself, wouldn't I have done it by now? Even if I didn't want to fix myself, I wasn't exactly happy. Anxiety and depression aren't exactly something to aspire to, are they?

I'll never forget the first session of Solution Focused Brief Therapy (SFBT) I had with Vicky. She was everything I hadn't imagined. I knew quite a lot about the different kinds of therapy for people who

had mental health difficulties/ differences, but not about SFBT. I have to admit I was very taken aback during my first session with Vicky. Nothing was mentioned about SFBT, but it sure was different to the sorts of therapeutic exchanges I had experienced in the past. I have to admit in the back of mind I had this niggling concern: "was this lady really qualified? Did she know what she was doing? Did she even care?" She seemed to be asking a lot of rather random questions. A few sessions later though I had succumbed unknowingly to the powers of solution focused approaches, and (even better) went away with some self esteem and hope for the future.

Why, if I had received so much support from other more 'problem-focused' therapies, had I not felt better or hopeful before? Why had I often felt worse, more negative, with even less energy at the end of these sessions? Was I stubborn, would I not acknowledge the issue; did I not want to get better? No. What I had been searching for all of this time was someone to acknowledge that I was a person, that I was not a diagnosis, or a problem, or that my 'self' was the sum of my mental health notes. Actually I didn't want to change myself much at all; I wanted to

know how to cope. I wanted to have my own expertise acknowledged. I wanted someone to acknowledge all of the coping strategies I had used, that I hadn't even been aware of myself. After all I was still here wasn't I? I must have been doing something right? I learned so much about myself from the SFBT sessions, and not only was it good stuff, it was useful stuff! I wasn't dependent on the therapist to fix me. In fact I'd never wanted to be 'fixed'. I wanted strategies and solutions to help me help myself. After all, who knows me better than me? No-one but me. What Vicky did was remind me and bring to the fore all of the skills and coping strategies I did have. I had suffered difficulties on and off for a long time, and yet... I was still here and going strong! No-one had ever focused on that before. The things that really struck me when going through the sessions were the exclamations of genuine amazement from Vicky ("Wow!", "How did you do that?", "Good on you" and so on). I went away from sessions feeling like a truly competent individual.

In terms of having a diagnosis of mild Asperger Syndrome (AS), SFBT has worked a treat. For the purposes of clarification, Asperger Syndrome is classified in the DSM-IV- Revised Text (APA, 2000) as a mental disorder affecting verbal and non-verbal language use and comprehension; difficulties with social interaction and problems with inflexible thinking often leading to all-absorbing interests and obsessions (well that's the problem-focused way of looking at it). I had always

known that much of my anxiety and depression stemmed from being 'different' and feeling alien (which was later explained by a formal diagnosis of Asperger Syndrome) from my neurologically 'typical' peers. However, I wasn't really interested in changing the way I was, label or no label. What made me anxious and depressed was living in a world where seeing things from a unique perspective (as many an Asperger individual does) can be isolating, confusing and frustrating. The cure for Asperger Syndrome, it seems, is to allow an individual their own world, which is one without others to bring social challenges. Asperger individuals have a different, minority brain wiring which I would like to think of as a difference rather than a disorder, which brings as many positives, and in the right environment, more positives than negatives. Living in a minority, however is tough and it is not surprising that many AS individuals suffer from high levels of anxiety and depression. Having good psychotherapeutic support for this group is necessary and in this case bad mental health support is worse than no support.

Since doing this work with Vicky a while back now, and learning what this work was all about, I have been bitten by the Solution Focused 'bug'. Ok, so I still have AS, I have still have anxiety and I still have depression, but they are much shorter-lived and I come out more positive and stronger every time I have episodes of illness. I am now encouraging Vicky (who unsurprisingly is often anxious



Vicky has an MA in Counselling Psychology, and is currently completing the MA in SFBT at the University of Birmingham. She has over 25 years' experience of working with adults who have intellectual disabilities, autism or mental health problems, most recently as the Managing Director of the Missing Link Support Service in Lancashire.

and exhausted herself, not being a perfect professional fixer) to develop the approach to be used to positively support Asperger individuals. At the moment training those who work with AS individuals who will listen in using the approach is as far as we have got. Money for research would be nice, but for the moment anecdotal evidence is looking good. Plus, we are writing a guide too, entitled *A Preferred Future: Using Solution Focused Approaches to Positively Support Individuals on the Autism Spectrum*. It will be published by Jessica Kingsley Publishers in London soon, so if you are interested to know more, look out for it.

Vicky's Bit

How I laugh to learn that Gen wondered whether or not I was actually qualified as a therapist! And it is wonderful to learn that not being a 'perfect' psychologist-type is part of what works for some people because I feel like a bumbler in rumpled clothes probably ill suited to my figure (because my mum has stopped dressing me now) and I wouldn't be at all surprised to learn that a faint whiff of animal scents follow me into and out of every room. My best guess is that it is easy for people to see by the outside of me that I have no therapeutic plan on the inside of me, and I would understand if people were a little concerned by this chaos. The truth is, neither of us, before entering into a discussion, know whether or not I am qualified to be a therapist for any one particular person. Gen didn't know if I was qualified to be her therapist, and neither did I in the beginning. As it turns out, apparently I was!

I remember meeting Gen in her home, noticing her wonderful facility with spoken language and her obvious experience with noticing problems. As happens with SFBT, every mention of a problem hides some sparkling coping skills and exceptions, and Gen just laid one after another in my lap for comment. She had strengths sneaking up and surprising us both! It quickly became apparent that Gen was yet another

perfectly reasonable person in a perfectly unreasonable situation – I just keep meeting people like this! The people around Gen, such as co-workers, people at University, and unfortunately past mental health care workers, had been skilled at making it appear as though Gen, herself, was responsible for the fact that they didn't understand her. It didn't take us long to discover just who the crazy, crooked thinking people were in this particular scenario and start co-constructing a version of the future where Gen got to be herself and get what she really really wanted and mobilise her resources and look at neuro-typical people (i.e. 'normal' folk) for the illogical yet emotionally gifted people they were. HA! 'Gen with the problems' has now written three books to help other people with autism and even better, has chosen me (the disorganised pseudo-professional) to co-author her fourth book! How brave is that? She is also an accomplished public speaker who has touched the lives of many people and given hope and help where there was none before.

Gen, along with every other 'therapee' I meet, was, and continues to be, a gift to my education and to the richness of my life. It is extremely gratifying to learn that I had a useful role to play in helping her to move forward and a great relief to know that I didn't have to be well dressed, problem-focused or typically professional in order to do it. All I had to do was notice and name the existing competencies, strategies, strengths and skills which positively tumbled out and piled up around her whilst drinking tea and talking about horses. Well, ok. We talked about other things too. And sometimes I only drank water. And always there were positive things going on which Gen worked out how to do more of whilst I said "wow" and "how did you do that?!" quite a lot. Is this a good job or what?

Reference:

APA (American Psychiatric Association) (2000) Diagnostic and Statistical Manual of Mental Disorders: 4th Edition – Text Revision (DSM IV-*Tr*). Washington DC, US: APA.

BOOK REVIEW

Edited by Bill O'Connell & Stephen Palmer. (2003). Handbook of Solution-Focused Therapy. London, Sage Publications. 180pp. ISBN: 0-7619-6784-2. Reviewed by Beth Billington

Best hopes for reading this book: In reading this book, I was hoping to gain a basic insight into the theory behind Solution Focused Therapy (SFT), as well as ideas of how this is applied in different contexts. As a psychologist, I was hoping to be inspired by other people's use of SFT, and also to develop my ideas around the usefulness of this therapy in my clinical work.

On a scale of 0-10... I would give the Handbook of Solution Focused Therapy a nine – it met my best hopes in terms of an insight into the theory and mechanics of SFT, and gave me ideas for extending my current use of the therapy. I found it engaging, readable and well-presented, with useful reference lists within each chapter to guide further reading.

Bill O'Connell (Ch. 1) opens with a clear introduction to the solution-focused approach, and Alasdair Macdonald (Ch. 2) then outlines the current research base of SFBT processes and outcomes, as well as research specifically in the areas of child work, adult mental health, alcohol and violence. This chapter argues convincingly for SFT as a cost-effective, evidence-based approach to initiating change.

I was particularly impressed with Pat Hoskisson's (Ch. 3) and John Sharry's (Ch. 5) chapters on the use of SF ideas with groups and parent training. I found myself imagining an SF group running in parallel with a more traditional mental health or parent training type group and considering the very different experience for group members. These chapters painted a hopeful picture of the resources brought to a group by the members and potential to share ideas within the framework of SFT. The chapter on reflecting teams (Harry Norman) also highlighted for me the applicability of SF ideas in thinking as a team and sharing a vision of a preferred future.

In chapter 4 Guy Shennan outlines the processes involved in family work from an SFT approach and Chris Iveson (Ch. 6) goes on to describe the use of SFT with couples. This chapter clarified for me the reality of working with conflicting wishes, and the power of SFT to be respectful of each person's wishes, even when they are diametrically opposed!

The book dedicates two chapters to the use of SFT in educational settings (Nigel White – SFT in higher education and Harvey Ratner – SFT in schools) and one further chapter on solution focused practice in social work (John Wheeler). Although these chapters were not directly relevant to my clinical work, I found them to be extremely interesting.

Jane Lethem (Ch. 11) discusses the use of SFT with women, outlining the gender differences in the way we discuss problems and the role of socialisation in the development of women's thinking patterns. I found that this chapter raised gender issues that I had not previously considered, and it also made me wonder whether anyone has written about the applicability of SFT cross-culturally.

In terms of presenting problems, this book includes chapters on mental health (Tom Dodd), sexual trauma (Melissa Darmody), substance misuse (Paul Hanton) and psychosis (Dave Hawkes). I found the chapter on mental health difficult to read, but liked the presentation of the values framework of SFT.

To reach 10/10... In writing this review I realised that the chapters (aside from the opening and closing ones) were in no particular order that I could discern. In summarising such diverse contributions, I found myself wanting to group the chapters, and then came to wondering why they weren't already ordered in terms of working contexts or lifespan, for example. The result was a very interesting read, if at times a little jumbled in terms of chapter order.

As a therapist, the majority of the chapters were directly relevant to my work, and this led me to wondering whether professionals from different backgrounds would have found as much of the book practically useful. I have no doubt however, that anyone with an interest in SF approaches would find interesting ideas across the whole book.

I would have liked this book to have included chapters on using SFT ideas with individuals who have learning disabilities and people living with chronic illness or health difficulties. However, the handbook of SFT successfully achieved a delicate balance between depth and breadth of coverage. This book is an ideal starting place for anyone who is curious about SFT, and could be described as a core introductory text.

A Solution Focused Approach to Reducing Waiting Lists in Community Health Services

Carole Waskett brings hope and suggestions for a problem that can leave us feeling hopeless and helpless.



Carole has been working in a solution focused way since 1995 - chiefly in primary care counselling and more latterly in teaching staff in the NHS, although she believes SF can be a helpful and constructive approach in almost any setting. She enjoys doing coaching, supervision and consultancy, and training in a wide range of contexts. Her website is at www.northwestsolutions.co.uk

Summary

This paper focuses on those clinical services whose patients live in the community and attend for a series of treatment sessions. It considers some of the influences on waiting list management, and introduces five major factors which can be addressed to reduce waiting lists. This is not a research-based document. These ideas emerged from long experience in primary care counselling teams, followed by extensive work with a range of allied health professional services across many UK National Health Service Trusts.

Introduction

In many sectors of the UK National Health Service (NHS) work, practitioners can make changes which will reduce their waiting lists. Some examples are those in primary care counselling and all sectors of outpatient mental health; dietetics; physiotherapy; occupational therapy; speech and language therapy, and rehabilitation audiology. Solution focused thinking keeps surprising us with new applications, and this is yet another!

How can we do this?

There are many factors which can influence waiting lists. For the purpose of this article, let's assume that there is a set number of workers able to deliver a set number of hours to run a service.

Here are some key factors:

1. Are your referrals appropriate?
2. Did Not Attends (DNA)
3. How professionals deal with cancellations and DNAs
4. Number of sessions offered
5. How we can use solution focused conversations to enlist patient's motivation and co-operation.

1. Are your referrals appropriate?

How many referred patients are seen once and then never return, are referred elsewhere after assessment, aren't sure why they are there and don't particularly want to be, or could have dealt with their complaint themselves if only they'd been provided with, for example, suitable information, self-help materials, details of a local charity, helpline or advice from another professional?

How much time do you and your patients waste because a referrer did not know who which service or professional to refer to, and inadvertently got it wrong?

- How educated are your referrers about what your job is, and vice versa?
- Do they know the characteristics of a good referral into your service?
- Are the referral letters they send you, and the feedback letters you return to them, optimally useful?

How can you help your referrers to refer accurately? Written materials? Two-way shadowing? Joint training time?

Self-referrals into services are increasing too. How can you help potential patients to understand what your service can offer? How can gatekeepers encourage appropriate self-referrals, and deal helpfully and respectfully with inappropriate ones?

2. DNAs – Patients who do not attend.

This means people who have an appointment and simply do not arrive. They do not contact you or the service to let you know why they have not come.

There are as many reasons for DNAs as there are patients. Mistakes are often made, by ourselves in the health service and by patients themselves. Sometimes the condition for which the patient wants help affects attendance, for example in memory loss due to head injury. People with respiratory problems may find it hard to make a morning appointment. And life can be very unpredictable; the cat really does have kittens; the car really does break down, and sometimes the dog even eats our homework.

In a primary care counselling service, a man was referred for a first appointment. He did not arrive. Instead of just sighing and wasting

another hour, the counsellor investigated the circumstances. She found that:

- He was a male teenager
- He was depressed
- His father had asked the GP for a counselling appointment for his son without the son's agreement
- The appointment was offered at 9am.

Was it any wonder this was a DNA – and an avoidable one?

"It is important for a service to have a universal policy that is respectful"

From a small anecdotal email survey, below are a few possible solutions to the DNA issue. One or several may be appropriate depending on the type of service.

1. Reminder by text
2. Reminder by phone
3. Reminder by letter
4. Changing the lead time to the appointment – e.g. changing appointment from 3 months ahead to 1 month ahead
5. Altering the text of an appointment letter to make it more welcoming, informative and patient-friendly
6. Sending a letter to invite the patient to phone for an appointment of their choice
7. Addressing the issue of GP referral practices
8. Paying the patient to come
9. Charging the patient if they don't come
10. Asking the patient to call for an appointment near the time an appointment will become available
11. Addressing transport problems for patients
12. Involving patients to give the service advice regarding DNAs
13. Refusing further appointments to patients who DNA a first appointment
14. Telling patients the above in the first invitation letter.

3. How professionals and administrators deal with cancellations and DNAs

It's important for a service to have a universal policy which is respectful and avoids a punitive flavour. The policy has to be clear, transparent to all - including patients from the beginning - and applicable to all. It has to be flexible enough to take account of problems like sudden illness, transport or weather problems. But it must not waste professional time.

If the patient does not arrive and never contacts you at all, then what do you do? Doing nothing may be inequitable and deny a service to someone with no phone, who may not speak English, or who may have been taken ill, or is dealing with some other emergency.

A happy medium here is clearly necessary. Would a telephone call or an email be intrusive in your service? Or you might write and offer another appointment. This would take account of the patient's lifestyle; see the young man with depression above, or the single parent with school age children, or someone with difficulties with activities of daily living. Administrative staff may be very involved here, and may appreciate some extra training time; they may also have invaluable fresh ideas, particularly around creating new systems to fit new practices.

4. Number of sessions offered

In many disciplines there are a certain number of sessions agreed as standard. In some mental health services, for example, a standard of six sessions is common, regardless of individual need. In some other professions and with some stable conditions, clinicians can predict roughly how long they and the patient will need to meet.

At the other end of the scale, it can be easy to keep seeing patients endlessly. If the patient is not aware of the parameters and

the reasons for them, they may simply feel this is a helpful and open-ended service, and be unpleasantly surprised to be told - eventually - that it is not. There can be a disempowering imbalance between what the patient assumes about their treatment, and what the professional knows to be the case.

An ostensibly open-ended service may not even be particularly helpful. If a patient is seeing a podiatrist 'for life' to see to their corns, they may never take the decision to stop wearing ill-fitting shoes. If you get frequent hydrotherapy with a pleasant physiotherapist who feels more like a friend, it may not seem so important to do your exercises at home. And both patient and therapist may lose sight of any movement towards the patient's goal.

So how do we deal with this kind of stricture? I suggest we are open with patients. It's empowering for both patient and clinician to have an optimistic and hopeful conversation along the lines of "we have up to X sessions to work together". Patient and professional start on the same footing, ready to tackle the condition together. The professional reminds the patient of how many sessions are still available at every session, counting down and checking that what they are doing together is still helping the patient towards their goal. The patient may not require all the sessions, or may wish to put a session or so 'in the bank' if the bureaucracy is flexible enough.

With electronic systems such as open diaries on computer, and software such as Lorenzo, monitoring and audit can become much simpler, and it is easier to see where clinicians and patients are working together effectively and good practice is growing.

The way we use language, as well as our respectful and positive attitude and our willingness to tailor our skills to help the patient as well as we possibly can given time restrictions, can make an enormous difference.

5. How we talk to patients to enlist their motivation and co-operation

The practitioner can do this by having solution focused conversations with the following characteristics:

- a) Appreciating and amplifying the patient's strengths and resources
- b) Working with the patient to develop well-formed, achievable goals
- c) Being open about the number of sessions available wherever this is possible
- d) Asking the patient when and how they would like to use those sessions
- e) Using scaling to help the patient to identify milestones and small steps forward
- f) Counting down at every treatment session and regularly checking that the treatment is useful to the patient
- g) Creating arms-length, post-treatment support.

This way of talking enables the patient to use the professional to best effect, and the professional to focus on giving their best work in the time available.

Starting

How does a team or service begin to tackle a long and entrenched waiting list?

There is no standard answer or quick fix, but there can be a planned, consistent progression of steps, moving in the right direction over time.

Measurements

Begin by taking some baseline figures over a fairly average recent year. This will take seasonal variations into account. Within the ever-changing health service it is pointless to wait for a stable period, so other variables cannot be

controlled; this should not stop the work on waiting list management.

Notice success. For example, while 40% do not attend, 60% do. You could ask, what are we getting right with that 60%? What is your service's good practice? Why isn't your record worse?

Services and practitioners are accountable, and you may want to consider the good practice of particular referrers or clinicians who are especially effective as well as those at the other end of the scale. Open diaries and regular monitoring will render this information and help the whole service and its referrers to progress.

Forward Steps

You may wish to look at all or any of the following. I believe the first two points are crucial to success.

- 1) Wherever possible, a policy on the number of sessions offered should be developed – perhaps for specific conditions and with some flexibility.
- 2) Clinicians who learn about solution focused language can present limited sessions comfortably and transparently, collaborate respectfully with the patient, and amplify motivation.
- 3) DNA rates and an action plan to reduce them, using a policy that everyone understands and uses.
- 4) A 'bulls-eye' project to educate and collaborate with referrers.
- 5) Process mapping to trace the patient pathway and smooth glitches inside the system.
- 6) Clinical supervision to support staff.

"You may want to consider the good practice of referrers who are especially effective"

7) What else? What else? What else?

Plan a further audit after a reasonable amount of time, to measure progress and plan what you need to do next for further improvements.

Conclusion

Waiting lists will never disappear completely, but paying proper attention to managing them means that patients will be seen nearer the time when their motivation to get better - or manage their condition effectively - is high, their willingness to work with clinicians is active, and with luck their condition is relatively recent and not yet entrenched or worsening. Professionals can approach each treatment episode with a clear understanding of and respect for the patient's functional goals, and patient and

professional can co-operate in managing the treatment sessions in their inevitable shape of beginning, middle and end. Both partners can work together to make positive progress within the time available.

Hope, optimism, transparency and willingness to work together are the keynotes of any successful patient/clinician partnership. Using solution focused principles to maximise partnerships with these characteristics, together with some of the other changes described above, will, I believe, make a strong contribution to reducing waiting lists.

ASSOCIATION NEWS

A round-up of the work of the **UKASFP** sub-systems

Carole Waskett provides a summary of the general committee's work over the last twelve months:

The committee of six has met four times over the year (22/8/05, 5/11/05, 3/2/06 and 12/5/06), at Birmingham University, in Manchester, and twice at Harplands Hospital in Stoke on Trent.

What's been done? Your committee:

- Clarified finances, set up a deposit account and appointed an accountant to keep us on the right side of tax matters.
- Commissioned and set up a fresh new website which incorporates a discussion group and a membership directory.

- Oversaw the launch of an enthusiastic trainers' network, independent of the association but supported by it.
- Drew reasonable limits around what can be done regarding accreditation, and did some information-gathering about it.
- Made steady progress in doing publicity for the association.
- Cheered the international successes of Solution News.
- Fretted a bit at trying to help new local networks get up and running (established ones are doing very nicely without our help).
- Liaised with our invaluable 'satellite members' eg membership secretary, treasurer, conference committee, accreditation committee.

- Explored the idea of changing the venue and masterminding of our yearly conferences.

And finally . . .

Frequently reminded itself of the principles of transparency, simplicity and inclusiveness, and the hope of giving away power and authority to members whenever possible.



And at the Annual General Meeting...

- Dominic Bray stepped down as chair, Steve Freeman (former National Development Officer) was elected to replace him.

- Carole Waskett stepped down as Secretary, Beth Billington (also the co-treasurer) was elected to replace her.
- Barry White was voted into the new post of Web Manager.
- Ian Smith was re-elected as Newsletter editor.
- Phillippa Calvert was voted in as the New National Development Officer.
- The committee expanded its 'ordinary' members to three. Paul Hanton was re-elected, and will be joined by Beverley Young and Carolyn Emanuel.
- A group from Stoke-on-Trent won the bid to host the 2007 annual conference, which will now be on Saturday 16th June at Keele University.



The general committee wrote Dominic (the outgoing chair of the association) a letter of appreciation:

Dear Dominic,

Your 'old' committee will miss you! We wanted to follow your brilliant idea of a 'solution focused letter' and send you one too, telling you about just some of the great things about you that we've appreciated in working with you over these few years.

What comes to mind first is your calm. In our sticky situations – and we've had one or two – your contribution has often been delayed. But then you've summed up our thoughts, and when you've added your own somehow knots untangle, rages are soothed and fairness rules. Everyone who talks to you feels special, and when you chaired our group, we all felt special.

What else? Well, your intelligent farsightedness was noticeable again and again. Your 'state of the nation' notes to the membership summed up matters in a thoughtful, quiet way that laid out the ground, maintained hope and indicated ways forward. You have a way of putting things simply and gently which usually becomes easily acceptable to the most fractious member.

There is also your modest and peaceable demeanour. Chair of our Association is a big job, and you used the office effectively and well, keeping us all on track. You controlled what had to be controlled and used your authority appropriately, yet there was never a glimpse of pomposity – the mark, I imagine, of a man who is probably very secure in himself.

As the first Chair of our Association you've lent it your own special flavour; long may that last as the new committee and the new chair go on to the excitements and possibilities of the next few years. You've been an inspirational and trusted Chair. Thank you, wholeheartedly, from us all.

The 2005-6 General committee

CORRESPONDENCE

We welcome your views and comments on any article in Solution News, the UKASFP, or on any other solution focused topic. Send your correspondence to letters@solution-news.co.uk, indicating clearly whether you intend your correspondence for print or solely for consumption by the Solution News team.

Zen and the Path To Solution Focused Practice

Carl Plant writes about his path to solution focused enlightenment



Carl works as a Crisis Resolution Practitioner for the North Staffordshire Crisis Resolution and Home Treatment (CRHT), and also manages the Solution Focused Approaches in North Staffordshire web community. He recently presented at the Keele Conference on his experiences with Solution Focused Approaches and its similarities with Zen practices.

I should start this article by saying that I do not practice Zen Buddhism or pretend to be a walking encyclopaedia on Zen practices. However, if I were to ask you to look up Zen practices I'm pretty sure you will read that Zen is not a religion but a way of life, and not purely a conscious state. You will see that Zen is understood as a synonym of simplicity, wisdom, enlightenment and briefness. You will see these elements reflected in Zen art with the simplicity and naturalness being common features. In Zen art, anything can be painted or expressed and in music anything can be played. Within language, Zen practices use words as a tool between the teacher and the student, very much dependent on the sounds and phrases used. The roles of teacher and student are interchangeable in Zen teachings too, it being said that 'if the student can not be allowed to be a teacher then there is no future'. The state of mindfulness referred to in Zen teachings can also be seen in Solution Focused Therapy (SFT), where the client is allowed some emotional respite from the problem but without 'false detachment', which allows the client to have a fuller, richer life outside of the problem. So I have seen many of the elements of Zen within the solution focused approach, and looking back over my past experience I wish I had been enlightened years earlier!

I began my career in health-care working with individuals with intellectual disabilities, which is when I first knew I was finding my niche in life. Looking back to this time I can recall feeling that something was still missing in the way I worked, although I could never put my finger on it. I returned to college doing part-time studying and then eventually to university to study mental health nursing. This then led to my first job as a fully fledged nurse in acute mental health services.

There then began a steep learning curve for me as I desperately wanted to be the approachable, knowledgeable and expert nurse (the teacher). But still I had that feeling that something was missing in my approach. Although I had been trained in a range of skills and had gained a range of knowledge and terminology to help patients recovering from mental illness, I still felt that my impact was limited, which was frustrating.

My next job was on a neuro-behavioural ward, which I must say is where I really noticed strengths-based and patient focused care. It was during this time that I became aware of the solution focused model and joined a local interest group. However, whilst the simplicity and naturalness of the approach fitted with my own characteristics, and I kept in touch with the other SFers through email, I found it difficult to see how I could

use SFT techniques with people who were recovering from brain injuries.

It was only when I moved to my current job in a crisis resolution team that I realised that solution focused techniques couldn't only be used in therapy, but in many other situations. I guess this was a turning point for me. I began to realise through contact with people experiencing a mental health crisis that I was not the teacher but a student (or in other words a guide), whose role was to help them seek out solutions to their situation. I have never stopped being amazed how people cope with such severe and challenging situations, and now I recognised that helping people to focus on solutions rather than the problem was the missing element I had searched for.

Our team are often called to support people who have attempted suicide or are experiencing acute psychosis. These situations are extremely challenging and require a huge amount of emotional and mental energy and the SF approach works well because it is flexible, future focused, hope inspiring and patient centered. Although the main emphasis of the approach is on simplicity and language, the thought processes you need to go through are challenging and complex. When you are faced with an individual in crisis you have to quickly establish an empathic relationship between yourself and the client that is based on trust, confidence and is itself hope inspiring. There is a huge amount of energy spent on active listening, to be able to notice exceptions to the problem and make small inroads into establishing signs of safety (an SF risk management tool that looks for exceptions to the ongoing risks, coping strategies and plans to reduce the risk from the individual).

I am one of a number of people who have perceived a connection between the solution focused approach and Zen ideas. The beauty of the simplicity, the use of language and relationship developed with the client are just some of the links. I have become aware now that I am not the expert but a guide and that I no longer need to take a stance based

purely on my knowledge, beliefs and values, and indeed doing so can lead to conflict and therefore 'resistance'. I have learned to accept that I have no cures or magic potions, but perhaps can offer guidance to the client. This self-awareness is my form of mindfulness. I am also developing my ability to clear my mind of preconceptions when about to face a client. This helps me to focus on active listening and not be waiting for the moment to intervene with my preconceived plan of action. Such 'letting go' requires great confidence in the approach as it requires you to meet clients 'empty handed' and to be able to create 'works of art' with very little.

"I have learnt there is an art to picking up on insignificant details to make master strokes of progress"

I have learnt that there is definitely an art in picking up on almost insignificant details and making master strokes of progress with the client, again a Zen-like feature. I am continually amazed by my colleagues' ability to pick up on signatures of hope and resolution to a crisis.

Sometimes, being allowed to share someone's critical periods of unrest is an intimate and daunting experience. You are invited into someone's lives to help them overcome extreme situations and it is while you become immersed in the details of the crisis that you look for these signatures. There have been occasions whereby the whole family have been in crisis and even the referrer has reached a critical point, and we are usually introduced to a complex problem whereby the language used signifies loss of hope, negativity and despair. The initial time spent with the individual and/or family is spent building up a rapport and it can be during these times that you notice some positive details, exceptions to the problems or signatures of hope, such as a religious symbols, pictures of children, pets or something said during the conversation.

The CRHT are usually the second or third set of professional to become involved in a crisis, and so the person and/or family will have already had to describe their problem on a number of occasions before we see them, which can give us the advantage of not having to ask for the details of the problem,

Ideas for Solution Based Working with People who Have Intellectual Disabilities

Ian Smith gives his 'top ten tips' for therapists working directly with clients

Only a few short years ago I believe the number of therapists using solution-based therapies in direct work with people with intellectual disabilities (ID) in the UK was not much above single figures. However, over the last few years many therapists working with people with ID have taken it upon themselves to develop and adapt solution based thinking to work effectively with their clients. Unfortunately it seems that they have been so busy doing this that few have had time to network with others or write about their work. A quick literature trawl on solution based work with adults with ID revealed only one case description of consultation work with direct care staff (Rhodes, 2000), my own case example of direct therapeutic work (Smith, 2005) and one outcome study suggesting that solution focused direct work is as effective as other direct therapy work (Stoddart *et al*, 2001). I know that there are some books out there in the pipeline (as Genevieve and Vicky mention in this issue) but to date there has been very little on what therapists have found actually WORKS. So in this paper I will offer my own 'top ten tips' for

those of you who may want to use a solution based approach with adults with ID, but are unsure as to how to go about it. What follows has been gained from a number of years of 'learning the hard way'.

Tip one: do some background reading

Most solution based work de-emphasises the need for the therapist to develop knowledge about 'the problem'. However, I don't believe that anyone should attempt therapeutic work with people with ID without at least a basic knowledge of the cognitive (and for that matter social) difficulties their client is likely to face. I can think of two main reasons for this. Firstly, only by knowing about the possible impact of factors such as language abilities, memory deficits, poor concentration and slowed information processing can the worker stand a good chance of being able to distinguish lack of ability from lack of motivation (tip three). Secondly, such an understanding is vital to ensure good and helpful communication during the therapy session (tip four).



Ian is a Clinical Psychologist who has been using solution based approaches with adults with intellectual disabilities for a number of years. He now works part-time training Clinical Psychologists, and part time working with people with psychosis. He is also available to provide training, supervision and therapy, either face-to-face or online. He can be contacted at ian@sftp.co.uk.

Oh, and he also edits *Solution News*.

Tip two: walk the line between assuming resources and disability denial

There is a basic tension that I suggest you keep in your awareness at all times if you are to be the most helpful therapist you can be. The dilemma is this: the solution-focused philosophy contains an assumption that the client already has the skills, resources and competence to overcome the difficulty they bring. Conversely, adults with ID BY DEFINITION are less able than others at some cognitive and social skills. I believe strongly that it is important that the therapist recognise this, and that they should NOT ASSUME a LACK of skill or competence in any area, but at the same time they need to be aware of the potential impact that real cognitive difficulties can have upon a client's ability to converse, comprehend and implement changes, as a failure to recognise and appreciate such difficulties can be equally damaging to the client. The example in the next tip will hopefully illustrate this.

Tip three: distinguishing lack of ability from lack of motivation

I have frequently come across people with disabilities who have been labelled 'awkward', 'depressed' or 'non-compliant' when actually they simply are not able to do what is asked of them. A simple example might be a man I worked with who (like many people with ID) had a 'working' (very short term) memory limited to only two or three items, and so sometimes couldn't manage when staff gave him complicated instructions for (for example) getting ready to go out. As a result the poor chap could end up sitting on his bed, confused, wearing his hat, whilst the staff complained that "he says he wants to go out, but then changes his mind when it comes down

"It is perfectly possible to conduct sessions without using words longer than three syllables, and still stay respectful and non-patronising"

to it. He must be depressed / attention-seeking / agoraphobic" (delete according to you preference). So bear in mind that all people sometimes need is enough of the right external help to carry out the activities of everyday living.

Conversely, therapists are usually asked to see people with ID because of concerns of a carer or member of staff rather than because the person with ID themselves wants to be seen, so your client may well have absolutely no motivation or desire to see you at first and may well be fearful and do all they can to make the encounter as short as possible. So, when you first see clients it is important that you are able to engage them quickly to help put them at ease. Fortunately, some solution based techniques are particularly suited to this purpose. Just remember to get your problem-free talk and resource conversations in early!

Tip four: mind your language!

Most people with intellectual disabilities will have a more limited vocabulary than most therapists, and it is important to remember that a person's ability to express themselves verbally is not necessarily at the same level as their ability to understand what is said to them. Assuming that you don't already have a detailed report on your client's verbal skills, what then are you to do? I would suggest that, contrary to what many people might think, it is perfectly possible to conduct therapy sessions (or many other types of conversation) without the use of words longer than three syllables, and still keep a tone that is helpful, respectful and non-patronising. If you don't believe me, try it out tomorrow at work!

It is also helps to use short, simply constructed sentences. People with ID commonly have trouble understanding

passive constructions, can be confused by anything other than basic verb tenses or the use of multiple adjectives and / or adverbs in the same sentence. So keep it simple, and if you're not sure you've been understood, apologise to the client for not being very clear and ask them to explain back to you what they've understood!

Avoid the use of ANY technical language (I recently heard a therapist ask someone "and what support mechanisms do you have for when things go wrong?") and most importantly LISTEN TO and use your client's own terminology (once you are sure what they mean by it) – it really helps you (mis)understand each other better! For example I recently worked with a woman who called all the health, education and social services staff who worked with her 'fessionals' (professionals). By us both adopting this phrase, we were not only able to communicate more efficiently with each other, but also I was constantly kept mindful of her perspective, which put all the 'fessionals' in one category and unless they worked particularly closely with her, made their roles and identities (as far as she was concerned) interchangeable.

Tip five: facilitate choice

Even solution focused therapists rely heavily on asking questions of their clients, but a common experience when asking open questions of people with ID is that an embarrassed silence follows. This may well be because the person you are talking to needs more context to be able to answer the question, that they have trouble initiating a response, or it may be they are looking for but can't find cues from you (because you are managing to be one-down) as to what the 'right' answer is.

The simplest way to reduce these silences and facilitate work is to offer multiple-choice options. However, this creates its

own difficulties for two reasons. Firstly, some people with ID may regard it as more important to give an answer that they think will please you or will make them seem most competent in the conversation, rather than to tell you what they really think. If this is the case they may look for any cues you may give to find the answer you 'want'. The second problem lies in the fact that by constructing multiple choice questions, you are of course closing down the possible responses and 'directing' the conversation, which restricts your ability to 'lead from behind'.

To attempt to overcome this I ask a whole range of multiple choice questions, some very broad ("are you an indoor or outdoor person?") and some more specific, and never assume that an answer I get is the 'final' one. By changing the order of options and frequent checking you've got it right, you should eventually confuse your client so much that they will give in and tell you what they really want!



"If a tool manages to help a client describe what better and worse looks like, then it's working!"

Tip six: seek resources through preferences

People with disabilities go through much of their life being told what they CAN'T do, and are very rarely encouraged to talk about their strengths. Even when others talk about them they often seem to emphasise only those strengths that match their 'dependent' role (such as "she's very loving" or "he has a great smile") or allow others to blame them (e.g. "he understands everything we say though").

The most valuable thing I've learned in seeking strengths is that you can get there through the 'back route' of asking people about what they LIKE. This has three advantages: 1) Talking about preferences and likes is not a taboo subject like talking about strengths, but instead is encouraged by the normalisation agenda, 2) People love to talk about what they like, and 3) People usually

like things they are good at! So having these kinds of conversations not only helps you build relationships, but it can also lead into resource talk and compliment-giving in a way that its likely to be accepted by the client.

Example:

Worker: What do you like to do in the afternoons?

Client: I like it when we do cooking, making cakes and that.

Worker: You can bake cakes? Wow, I've never been able to do that – I always end up with a burned mess when I do it! How did you learn to do that?

Tip seven: exception seeking, preferred future and miracles

First of all, it may be worth role-playing the problem situation, and then doing it again but this time using a 'preferred future' alternative, or using an exception the client relates. This is particularly helpful when the problem relates to social encounters, and can help the person you are working with test out whether their preferred future is practical, and in the process may reveal some strategies for getting there.

In more general terms of a preferred future, I often find it useful to take a step back and ask the client concrete questions about their regular morning routine. Where do they sleep? What time do they wake up? What's the first thing they normally do after they open their eyes? Etc. Only then should you ask the preferred future question, asking them about what changes might happen with regard to these concrete everyday things if the problem improves. You might be surprised by what little details working someone through the day this way can produce – I remember one person who wanted to lose weight telling me they'd get on better with their boss. We had worked this out because they knew they would arrive at work on time and in a better mood more often, because they would have more energy and wouldn't have had to run for the bus.

An alternative preferred future question I have found quite powerful is to ask "If you won the lottery this Saturday, what would your life be like in a few months time?" followed by specific concrete questions such as "where would you be living? (in a house / flat, local / somewhere else)", "who would be living with you?" "What would a typical day look like?" etc. However, I recommend NOT using the traditional miracle question with your ID clients. It's way too complex and abstract, and I have found the ways of eliciting a preferred future described above to be far more effective.

Tip eight: be flexible in your scaling

There is a whole range of ways to make scaling more relevant and helpful for people with ID. The most obvious way is to physically draw the scales, and perhaps use pictures or graded facial expressions to help prompt people into making a choice. However, bear in mind that whilst some people with ID have visual (right brain) cognitive skills that are significantly better than their verbal (left brain) skills, there are equally a number of people who have better verbal than visual skills and so find talking less confusing than using pictures. Ultimately you'll need to experiment with each individual client to see what they find most helpful. Don't forget, scales don't have to have ten points (if your clients can't count to ten) and don't even have to have points at all! I frequently ask clients "on a scale of me to that door, where I am the worst you've ever been and the door is the problem has gone away forever, could you stand where you are today?"

Just always bear in mind that scaling is all about helping people draw DISTINCTIONS between their experiences. If a tool can help a client describe to you what better and worse looks like, then it's working.

Tip nine: use other people as 'helpers'

People with ID often can't remember (especially cognitive) tasks, and so I use prompts or helpers whenever possible. However, I am acutely aware how easy it is for even well-meaning staff or carers to 'take over' the intervention, and so choose both my words and the helpers very carefully, and in collaboration with the client. When I suggest it, clients often tell me they would find it useful to meet with a member of staff each day to talk about the day's events in light of what's different. I always prepare staff for this with the phrase "The client has told us that it would be really helpful to him/her if you could" and give them a detailed briefing on how to conduct these sessions. Other times we will use messages (if the client can read) or 'objects of reference' placed to remind the client of something or other. If the client is willing, I also sometimes include a carer that the client knows very well and trusts in sessions so that they can act as a 'memory resource' for the client in-between times. However if I do this I am careful to ensure that carers are fairly passive during sessions, and that the client is in the driving seat.

Tip ten: you don't have to do everything!

My experience of using a solution based approach with people with ID has told me that it is often only one aspect of the solution based repertoire that the client finds useful and that makes a difference, (and that element is different for each client), but it nevertheless can be enough to bring about enormous changes. Don't feel you have to use EVERY solution focused technique or keep to any fixed structure. And bear in mind that some clients might need to have sessions longer than an hour, whilst others may only be able to concentrate for ten minutes at a time. Be prepared to be flexible!

References

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REVIEWING BOOKS

Let us know what you think of a book... Solution News has a number of books available for members to review. If you would like to review one of the books below, or another book, please contact books@solution-news.co.uk.

Books currently available:

- The Solutions Focus - The Simple Way to Positive Change by Paul Jackson and Mark McKergow
- Team Coaching with the Solution Circle by Daniel Meier
- Solution Focused Stress Counselling by Bill O'Connell

We are always looking for more books to review. If you would like to make a book available for review, please get in touch!



Return of the SOLUTION GNUS



They're back! After the helks left us helpless last issue, with no-one to quiz about the queries we received from readers, they came swanning back from the savannah to the *Solution News* offices expecting to be allowed to dive straight back into dealing with your doubts and queries. But readers had already stepped into the breach, so all the gnus had left to do was pick their favourite replies before they went off for a kip. Send your questions to gnus@solution-news.co.uk for next issue, by which time we should have woken them up!

Dear Gnus, Is there any point in taking a break in solution focused sessions, and is there any advantage to NOT having a break?

Alasdair MacDonald gnu. He said:

The founders of brief therapy and many of those therapists who come from a family therapy tradition believe that it is useful to take a break in order to compose the feedback. It is in the nature of human interaction that we are affected by one another's emotions and this is one of the pleasures of human existence. However, when clients are anxious and unable to reflect, we will be affected by this if we are in close contact with them. It is a common experience that appropriate responses occur to us just after we have left a situation. Taking a break allows us the cognitive space to think more clearly about their situation and about what comments will be the most useful. In traditional therapy this thinking takes place between sessions. A break gives the clients the advantage of this process of reflection within the same session. In our teams we found that more effective responses were composed if a break is taken. Some therapists regard a break as unnecessary and as causing an interruption in the therapeutic dialogue. Some therapists can compose feedback without this pause, but I find that it distracts me from the client if I try to plan the feedback while the conversation is still going on.

Joe Windsor also gnu, and he said:

Solution focused sessions are free-flowing, but they must focus on the client. Some clients need to look inwards and concentrate on their inward knowledge. So they benefit from a break. Others need the momentum of the session to help them onwards. The important thing is to adjust to the client's style and needs.



Why are there so many men in the solution focused world? Is it a 'masculine' approach?

Alasdair MacDonald gnu this one too! He said:

In my experience of every EBTA conference since 1994 and of many other solution focused gatherings either genders are about equally represented or females outnumber males. UK meetings tend to have more women than men, because many health and social work professionals in the UK are female, unlike much of Europe or the USA. Many of the most famous and successful therapists and presenters in SFT are female: Insoo, Yvonne Dolan, Eve Lipchik. The influential female trainers and therapists in the UK are too numerous to mention.

Your own masculinity or femininity will influence your work and your interpersonal skills as a therapist. This is expected and unavoidable. It highlights that although we mostly ask the same questions, we all bring specific skills and twists to the work. Psychotherapy generally shows that people have a small preference for a same-sex therapist or a female therapist. However, clients differ a lot in this and no specific link to therapy outcome has been found.

Is there really any difference between a 'miracle question' and any other 'preferred future question'. If so what?

Mark McKergow gnu:

One difference might be that the classical 'miracle question' involving a miracle happening overnight offers more of a new start to describing what happens next. There has been a miracle... so all kinds of things are possible. Steve de Shazer said the day after the miracle was "an effect without a cause" - things were better, but there was no idea (and absolutely no need) to wonder 'how' they got better. Other kinds of 'preferred future question', for example "How would you notice next week that things are better?" seem to be starting from the present, rather than leaping into a new and mysteriously better future. When I introduce the MQ in its classical form to managers, they often describe how liberating it is to be able to talk about what's wanted in this unconstrained way.

Another difference might be that the full miracle question has more than a hint of trance induction about it - it's set up in a very leading way, with a lot of reference to what will happen leading up to going to sleep and the miracle. Again, this seems to me to make a difference.

Joe gnu too! He said:

Yes there is a difference between the miracle question and a preferred future question. The 'miracle question' posits that 'something' has happened of which the client is unaware and this has an effect. The 'preferred future' question seeks a positive proposition from the client.

MEMBER NEWS

This section is for members to let people know about what they've been up to or is happening for them, and for requests for help. If you have an announcement, please post it to: news@solution-news.co.uk.

Announcements this issue:

Adam Barrow wanted to let you all know about 'Sheffield Solutions', a group of people from in and around Sheffield who have an interest in SFBT who will meet every now and again to share ideas, offer mutual support, and generally enjoy hearing about the way each of us use SFBT in our work. Their next meeting is on 13th July. For more details either contact adambarrow@tiscali.co.uk or Bryan Thornton (bryanthornton2003@yahoo.co.uk).



Paul Hanton has summarised the meeting that the trainer's group had recently in Preston:

There was a mix of trainers represented, including trainers that are training as part of an employed post, trainers that are training for a living, new trainers, experienced trainers, and trainers with 'specialities' such as supervision. It was felt that any network/support group needs to be able to address this variety of training. People were keen that a trainers' discussion group be set up on UKASFP website if possible, and also thought it would be great if trainers' CVs could be put on the web-site. The idea of regional groups of trainers meeting was felt to be a good way forward, and some trainers felt that they might benefit from observing others train (Paul offered to

do this with permission from customers). In terms of the national group it was felt that only one meeting per year (at the conference) might not be adequate, and so December was suggested for the next meeting.

If you would like to know more or join the trainer's group, contact Paul at paul@solutionfocused.org.uk



NEXT ISSUE:

An interview with another star of the SF world, plus our first peer-reviewed articles!

USEFUL WEB-LINKS

Download past (and present, and future) issues of Solution News (and coming soon, podcast versions) at www.solution-news.co.uk

UKASFP web-site and national email discussion group is at www.ukasfp.co.uk

European Brief Therapy Association web site is at www.ebta.nu

The SFT-L international discussion list is at

<http://www.isoftware.com/scripts/wl.exe?SL1=SFT-L&H=LISTSERV.ICORS.ORG>

SOLUTIONS-L is an international discussion list for those using a solution focused approach with organisations. It's at: <http://www.solworld.org/index.cfm?id=5>

The Brief Family Therapy Center (Milwaukee, US) website is at www.brief-therapy.org