Multiple choice questions

1. Solution-focused brief therapy is based on:
   a clear diagnostic formulations
   b appreciating the client's resources
   c a detailed description of the client's problem
   d the scientific study of personality
   e the use of language as a creative process.

2. Solution-focused techniques involve:
   a the 'miracle' question
   b paradoxical injunctions
   c complimenting the client
   d careful administration of medication
   e the patient's acceptance of the problem.

3. Solution-focused brief therapy has been effective in the treatment of:
   a drug and alcohol misuse
   b agoraphobia
   c adolescent behavioural problems
   d eating disorders
   e chicken pox.

4. Solution-focused authors include:
   a de Shazer
   b Lethem
   c Rollnick
   d O'Hanlon
   e White.

5. Scaling questions are used to explore:
   a the patient's achievements
   b the patient's description of the symptoms
   c medication requirements
   d possible areas for progress
   e goals of therapy.

MCQ answers

1	2	3	4	5
a F	a T	a T	a T	a T
b T	b F	b T	b T	b F
c F	c T	c T	c F	c F
d F	d F	d T	d T	d T
e T	e F	e F	e F	e T

Commentary

Michael Göpfert

I wholeheartedly support the publication of Iveson's paper (2002, this issue), although I have misgivings about it. I hope that my contribution will clarify this seeming contradiction. When I first encountered solution-focused therapy in the 1980s, a new world opened up before my eyes: all those patients with whom I had got stuck could be offered another opportunity of making progress. At the time I was particularly engaged with somatising patients, who mostly did not want to see a mental health professional because they seriously believed that their problems were of a somatic nature and needed an expert to provide solutions for them. For those patients solution-focused therapy provided a unique opportunity, as it clearly addressed issues within a psychological realm, yet I could take the stance of the expert who could prescribe solution-focused thinking as a sometimes helpful way of alleviating otherwise often intractable problems.

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For example, a patient with irritable bowel syndrome required all the tricks from the toolbox of solution-focused therapy but after a year's period of work, with sessions at increasing intervals, a significant degree of symptomatic relief and reduction in unhappiness had been achieved. This had been maintained in the face of adversity at the 6 month follow-up interview. Approximately 18 months later the person requested further time-limited in-depth work. Solution-focused therapy did not provide a miracle cure, but provided for a patient who was suffering significantly, and was difficult to help.

From my experience, the more short-term effective work might be easier to achieve in general psychiatric settings with an absence of waiting-lists and freshness and non-selection of problems. The average psychotherapy department in the National Health Service (NHS), with long waiting-lists and a relatively high level of complexity among the problems referred, might well have good use for solution-focused skills, but sometimes without the shine of quick and sometimes virtually miraculous work. It is the quick and miraculous improvement that can often cause some suspicion of the genuineness of solution-focused therapy. Just as with governments, if there is too much spin and not enough visible substance people cannot trust what is on offer.

I learnt about this on a case in which solution-focused work with a whole family produced dramatic and amazing changes in the identified patient (daughter) within a short period of time. However, her father's view was that nothing had fundamentally changed and the family terminated sessions. In view of this experience I would have liked Iveson to have explored in depth the complexities of solution-focused work with families.

Solution-focused therapy is most closely allied to the field of systemic and family therapies, although it also has much in common with cognitive–behavioural therapy. One of the dilemmas for the practitioner is that solution-focused therapy has to be applied in a fairly purist form. Problem-focused and solution-focused ways of talking cannot be readily combined. Undoubtedly, talking about problems can have the effect of reinforcing them rather than helping to find solutions, and therefore solution-focused therapy can be invaluable for the generic mental health practitioner in any part of the mental health field. It also can be very useful for therapists of any persuasion, provided that they have the ability to differentiate and integrate therapeutic approaches. However, what Iveson does not tell us is that solution-focused approaches can be unhelpful with more complex problems. This especially applies to some people diagnosable as having a personality disorder and their families. I also believe that solution-focused practice can carry the risk of being positively harmful if it colludes with the often symptomatic desire of our clients for a quick fix. The lack of outcome studies with long-term follow-up data is particularly worrying in this respect.

To my mind, one of the biggest shortcomings of solution-focused therapy is that its training culture is that of private for-profit training enterprise, rather than reflecting the needs of NHS patients. We still do not know when and where it is most appropriate to use or to avoid solution-focused interventions. However, unless solution-focused techniques are much more solidly integrated into public sector mental health services this knowledge may remain an illusive goal. I understand that there are now major efforts underway to evaluate solution-focused therapy in the NHS.

Brief solution-focused therapy is not sufficiently substantial as a modality of therapy in its own right and as a framework it lacks explanatory power. Nevertheless, it is based on radical assumptions that make it different from other ways of therapeutic work. It can provide a set of tools that can be used in all areas of mental health to supplement and enhance therapeutic work. The examples in Iveson's paper illustrate this well. I hope that it will encourage the reader to learn the elegant simplicity of solution-focused therapy, which can be very effective and easy to grasp.

Reference

Iveson, C. (2002) Solution-focused brief therapy. *Advances in Psychiatric Treatment*, **8**, 149–156.

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