Troy "discovers" Cognitive Behaviour Therapy!

Troy, aged 12 years. suffered last 3 years with anxiety every school holidays about returning to school, with almost constant vomiting for the entire school holidays.

His parents handled the situation appropriately — appropriate support and sympathy but also firmly ensured that he returned to school after the holidays. Troy would spend most of his time in sick bay, gradually improving over the first few weeks of term and, by the middle of each school term, he would have recovered. However, the next school holidays, the whole situation would repeat.

Troy and his parents had consulted their GP, who referred them to a child psychiatrist, had tried medication and had seen another psychologist — all without success. There had been various debates about Troy's diagnosis — was he suffering school phobia, separation anxiety, school refusal, generalized anxiety disorder, etc.?

When I saw Troy, it was midway through the term and he had no problem; however, his mother was keen that I should "teach Troy some strategies he can use when it happens next time".

I asked Troy to remind me about the previous holidays, just so that I was sure I understood the situation. He told me that he was excited on the first day of the holidays, thinking about the things he wanted to do, but then woke the next morning feeling "nervy" and a little bit sick, and by the next day or so he was vomiting constantly and was not really able to leave the house.

Michael: That must have been awful … not being able to go out all holidays.

Troy: Yes, it was.

Michael: Staying home the whole holidays. So what did you do.

Troy: Oh, not much. Watch TV a bit. … I wasn't feeling well enough to do much … I kinda just sat round the house.

Michael: Gosh, that must have been terrible. You weren't able to do anything for the whole holidays.

Troy: Nuh.

Michael: Nothing at all … the whole holidays.

Troy: Yeah, that's right. Nothing. Apart from Harry Potter.

Michael: Apart from what?

Troy: Harry Potter. I went to see the new Harry Potter movie.

Michael: You went to see the new Harry Potter movie?

Troy: Yeah.

Michael: Weren't you scared about throwing up in the cinema?

Troy: No.

Michael: Did you make sure you sat at the end of a row so you could make it out to the toilet quickly?

Troy: No … I didn't want to go out to the toilet 'cos I might have missed something in the movie.

Michael: So … did you get a really big popcorn bucket so you had something to throw up in?

Troy: No.

Michael: You didn't! So how did you manage to go to the movies when you've been throwing up all the time?

Troy: I don't know, I just did.

Michael: But, how did you decide it was safe to go? How did you manage not to worry too much about throwing up?

Troy: I don't know. I just told myself not to think about it all.

Michael: You told yourself not to think about it?

Troy: Yes.

Michael: Look … there's this thing in psychology called CBT — Cognitive Behaviour Therapy — and its this complicated psychological approach for helping people … and there's this thing in CBT called "thought stopping". It's a way to get people to turn off thoughts that are making them sick or worried. People have written whole books about it … and you discovered it all by yourself!

Troy: *[Looking pleased with himself]*.

Michael: So you've discovered something that psychologists have spent lots of time on.

We continued to discuss HOW Troy had done this — that he had told himself not to think about school; that he had listened to himself when he told himself this; that he hadn't ignored his own advice or argued with himself about it. I was amazed that Troy had figured out a way to overcome his problem that worked much better than anything doctors or psychologists had tried and that I certainly wasn't going to try to teach him any techniques or tricks, since I doubted I could be as successful as Troy had been.

I saw Troy early during the following school holidays, when his anxiety symptoms had recurred. We discussed what he had managed to do last holidays, when he wanted to go to the movies, and he thought maybe he could tell himself again just not to think about school. His symptoms subsided and he had a relatively enjoyable holiday. The next school holidays were symptom-free and, to my knowledge, the difficulties have not recurred.

WHAT DID I DO??

- I did NOT examine Troy's anxiety in any way.
- I did NOT try to get to the bottom of why he had this problem, how it had developed, or what the correct "diagnosis" was.
- I did NOT teach him any specific strategies for managing the problem.
- I did NOT do anything to try to solve or "fix" the problem.
- I looked for, and found, a time that Troy was already behaving differently.
- I did NOT explore WHY he was behaving successfully … I was more concerned with HOW he was doing it.
- Thus, the "solution" was Troy's own … and was already happening … so it becomes a matter of building on what is there rather than finding something that isn't there.

Insoo Kim Berg in London

Interviewing a 65-year-old woman who says she has been seriously depressed for more than 40 years.

"How do you cope?"

"I don't cope ... it's hell."

"So ... how do you get through hell?"

"I try to rustle up the energy to make a cup of tea."

"And that helps?"

"Sometimes."

"And when it doesn't ... how do you get through hell?"

"Well… I sit there and *think* about making a cup of tea."

The Future Focus

[Exercise in pairs]

1. Think of a change you would like to make in your life (personal, business, etc.) — don't tell me what it is.

2. Now, think of something that would be a very small sign to you that you had begun to make that change ... the first, smallest step (don't tell me what it is).

3. Now, let's imagine you do that very small, first thing ... how will that make a difference?

4. How will THAT make a difference?

Preferred Future

The idea that we had been having at BRIEF was that [the term] 'goals' did not adequately reflect the breadth of description following the 'miracle question'. We began to think of it as the client describing the future they would prefer to have rather than the future they seemed to be heading towards. It was then a short step to moving from 'exceptions to the problem' to times the preferred future is already happening (or, as the Milwaukee group began to say, "Times when the miracle is happening"). We must have met you around that time and found you to be thinking along the same lines.

— Chris Iveson

What if they give an unrealistic answer to the Miracle Question?

1. "What if they give an unrealistic answer to the miracle question?" — If we're careful how we ask the question, it rarely happens!

1. We first situate the miracle within the context of the client's ordinary, everyday life. "So … let's imagine … we finish talking here, and you do what you would normally do … you have something to eat, play on the computer for a while, maybe watch TV, annoy your sister a bit, maybe text a mate … and eventually, you go to bed …". If we situate the miracle in the context of ordinary activities, then the miracle itself is less likely to be out of the ordinary!

2. de Shazer comments how important the way we phrase the question is. We probably say, "… and, while you are asleep, a miracle happens". He reminds how important it is to follow this with:

   and, the problem that brought you here is solved, just like that! … . [Pause. Now the focus is on one particular miracle that is in line with his or her coming to see a therapist. Failure to include this focal point will often lead to the client giving a response that is vague, general, and so nonspecific as to be almost useless.] (de Shazer, 1997, p. 376)

   While we do not want to define the miracle for the client, we do quite deliberately place it in a particular context; that is, the context of this therapy conversation. The miracle is always placed in the context of "the reason we are having this conversation".

   … while you are asleep, a miracle happens … and the miracle is that the problems you came here to therapy about are solved …

   … while you are asleep, a miracle happens … and the miracle is that the things your mother was concerned about are solved …

   … while you are asleep, a miracle happens … and the miracle is that the things your doctor was worried about are solved …

   … while you are asleep, a miracle happens … and the miracle is that the problems that led to child protection being involved are solved …

   … while you are asleep, a miracle happens … and the miracle is that the problems your Dad thought you needed to talk about are solved …

   That is, we do NOT want to say (or communicate) that "the miracle is everything is wonderful".

   We always place the miracle in the context of "the reason we are having this conversation".

3. Similarly, we ask, "How will you now the miracle has happened?" or "What will be different that will tell you the miracle has happened?". We do NOT ask, "What will the miracle be?"

2. "What if they give an unrealistic answer to the miracle question?" — Just wait.

Often, clients are essentially pragmatic. They may offer an "unrealistic" answer to miracle question; however, if you don't panic and simply WAIT, often they will spontaneously redefine their miracle.

de Shazer comments,

> Years ago we hesitated to ask the miracle question in some situations, but — through experience—I have learned not to anticipate the client's responses and, furthermore, I have learned not to modify the question at all in anticipation of how the client is going to respond. For example, some years ago a client who had lost his left arm in an industrial accident came to see me. I hesitated and postponed asking the miracle question for as long as I could. I was afraid that he would say, as I am sure I would in that same situation, that the miracle must restore his lost left arm. Finally, after my teammates called in suggesting I ask the miracle question, I asked him and he gave the predicted answer. I did not know what to say or do, so I just nodded and sat there. After a brief interval, he said: "Ah, but you mean something that can happen." He went on to describe how his wife would greet him with a smile in the morning, how he would return that smile, how surprised she would be, etc. (de Shazer, 1997, p. 376)

If you receive an unrealistic answer to the miracle question, de Shazer suggests that you **just wait**, since they will often spontaneously become more realistic.

3. "What if they give an unrealistic answer to the miracle question?" — Take a deep breath … and just go with it.

Steve de Shazer comments,

> Insoo [Kim Berg] had a client whose initial answer was that her husband would be dead! Just exactly the most dreaded answer — one of the most dreaded answers that people imagine. And Insoo said, "Oh yeah, and what difference will that make?" And the woman starts to talk about going to see her daughter in Texas and her other daughter in California and, at some point in the interview, one or other of them said something like "I don't know why [my] husband has to be dead for this to happen" and away she went. (Norman, McKergow, & Clark, 1996).

We are exploring the effects of the miracle rather than the miracle itself, so it does not matter if the initial miracle that the client proposes appears unrealistic. The answer from a parent of a child with a disability — "She would be normal" — may well be unrealistic and (in this situation) physically and medically impossible. Nonetheless, as we question further about "how will that make a difference?", clients will often begin to describe much more ordinary differences ("the family won't be in as much chaos", "the day will start off less hectic", and so on).

The more detail we get of all the things that will be different "the day after the miracle", the more likely it is that a number of these things have happened or are possible. Then, we can go on and ask, "When was the last time any of these happened?" and so on.

4. "What if they give an unrealistic answer to the miracle question?" — Limit the scope of the miracle a bit.

Johnson and Webster, writing specifically about the use of Solution-Focused Brief Therapy with people facing chronic or terminal illness, discuss being flexible and adapting the miracle question a little.

> "Suppose a miracle happened overnight and while you were asleep you were endowed with the skills make this (problem) better, ultimately resulting in a better quality of life for you. What do you think you would notice the next day and in the following days that would give you the idea that this miracle had actually happened?"
>
> "Suppose a miracle happened overnight and you gained the ability to move beyond the problem that brought you here today."
>
> "…and you had enough energy to do things that matter to you."
>
> "…and you gained more hope."
>
> (Johnson & Webster, 2002, p. 127)

However, it is worth noting that Johnson and Webster conclude this discussion with the observation that, nonetheless, "the more general the reference to the miracle, the more possibilities generated by the question".

5. "What if they give an unrealistic answer to the miracle question?"— Use the answer to "How will you know coming here has been useful?" as a platform for the miracle question.

Interviewing a man who is confined to a wheelchair and who is in despair about his life, de Shazer asks "How will you know that coming here was useful?". Simon eventually replies, "Well, maybe I'd want to come back". de Shazer follows, "And what would tell you that maybe you wanted to come back?" and Simon replies, "Feeling better about myself'. Steve asks him when that has already happened. "And when was the most recent time that you felt good about yourself … as good as you can feel, given your situation?". Later in the interview, de Shazer asks the miracle question and says, "and while you are asleep, a miracle happens, and the miracle is that you're feeling as good about yourself as you possibly can".

At first glance, this might seem like limiting the miracle, in the way that Johnson and Webster (above) discussed. However, note that de Shazer uses the client's exact words from the previous discussion.

In the example of the woman who had a stillborn baby and is quite distressed, she is asked, "How will you know that coming and talking with me has been useful for you?". She replies, "I just want my life back'. And they embark on a gentle exploration of "what will be happening when you have your life back?" Early in the next meeting the therapist asks the Miracle Question — "… and this miracle is that, all of a sudden, you have your life back. When you wake up the next morning, how will you discover this miracle has happened? What will be different that will tell you this miracle has happened?"

> Like a compelling narrative, the most potent of all solution-focused interview questions, the miracle question, encourages clients to temporarily suspend their disbelief in regard to solving their problem while considering new solutions. This future focused intervention enables them to indulge in the benefits of the change process without being constrained by attitudes of "impossibility" of achieving it. The question is constructed to allow them to "work backward" from a seeming impossible solution endowing them with a miraculous kind of hindsight that ultimately facilitates a radically different perspective on a remedy to their difficulties. (Johnson & Webster, 2002, p. 126)

Coles, D. (2002). Dilemmas Around adopting a "strengths" perspective in relation to disability issues: The IFSO experience. *Australian Assoc. of Social Workers NSW Branch Newsletter, 1*(March), 15-18.

de Shazer, S. (1997). Commentary: Radical acceptance. *Families, Systems & Health, 15*, 375-378.

Johnson, C., & Webster, D. (2002). *Recrafting a life: Solutions for chronic pain and Illness*. New York: Brunner-Routledge.

Norman, H., McKergow, M., & Clark, J. (1996). Paradox is a muddle: An Interview with Steve de Shazer. *Rapport, 34*, 41-49.

Research on Solution-Focused Brief Therapy

There is growing evidence that SFBT is clinically effective.

Gingerich, W. J. & Peterson, L. T. (2013). Effectiveness of solution-focused brief therapy: A systematic qualitative review of controlled outcome studies. *Research on Social Work Practice. 23*(3), 266-283.

ABSTRACT: We review all available controlled outcome studies of solution-focused brief therapy (SFBT) to evaluate evidence of its effectiveness. Method: Forty-three studies were located and key data abstracted on problem, setting, SFBT intervention, design characteristics, and outcomes. Results: Thirty-two (74%) of the studies reported significant positive benefit from SFBT; 10 (23%) reported positive trends. The strongest evidence of effectiveness came in the treatment of depression in adults where four separate studies found SFBT to be comparable to well-established alternative treatments. Three studies examined length of treatment and all found SFBT used fewer sessions than alternative therapies. Conclusion: The studies reviewed provide strong evidence that SFBT is an effective treatment for a wide variety of behavioral and psychological outcomes and, in addition, it may be briefer and therefore less costly than alternative approaches.

Macdonald identifies

- 8 meta-analyses;
- 6 systematic reviews;
- 245 relevant outcome studies including 100 randomised controlled trials showing benefit from Solution-Focused approaches with 69 showing benefit over existing treatments;
- 73 comparison studies — 57 favour SFBT;
- Effectiveness data are also available from over 8000 cases with a success rate exceeding 60%; requiring an average of 3 – 6.5 sessions of therapy time.

SFBT is acknowledged as "evidence-based" by the US Federal Government (Substance Abuse and Mental Health Services Administration AND the Office of Juvenile Justice) and by the Australian Psychological Society.

For a more detailed research review, see Dr Alasdair Macdonald's up-to-date summary: http://www.solutionsdoc.co.uk/sft.html

SOME EXAMPLES OF SOLUTION-FOCUSED ASSESSMENT SCALES AND MEASURES

Please note that these examples are presented here solely for professional training purposes and not for distribution without the consent of the individual copyright holder.

Solution-Focused recovery scale for abuse survivors

Name: _____ Date:_____

For each statement below, circle the number that applies to you today:

0 = Not at all, 1 = Just a little, 2 = Occasionally, 3 = Some of the time; a fair amount of the time; 4 = Frequently or most of the time.

| 0 | 1 | 2 | 3 | 4 |	A. I am able to think/talk about the abuse or the sexual abuse when it is appropriate.
| 0 | 1 | 2 | 3 | 4 |	B. I am able to think/talk about things other than the abuse or sexual abuse.
| 0 | 1 | 2 | 3 | 4 |	C. I sleep adequately; I don't feel unusually sleepy in the daytime.
| 0 | 1 | 2 | 3 | 4 |	D. I feel part of a supportive family.
| 0 | 1 | 2 | 3 | 4 |	E. I stand up for my self (I am reasonably assertive).
| 0 | 1 | 2 | 3 | 4 |	F. I maintain physical appearance (weight, hair, nails etc.)
| 0 | 1 | 2 | 3 | 4 |	G. I go to work; I am on time, I am reasonably productive.
| 0 | 1 | 2 | 3 | 4 |	H. I am satisfied with my work.
| 0 | 1 | 2 | 3 | 4 |	I. I engage in social activities outside the home.
| 0 | 1 | 2 | 3 | 4 |	J. I have a healthy appetite.
| 0 | 1 | 2 | 3 | 4 |	K. I care for child, loved ones, pets. (I can take care of others.)
| 0 | 1 | 2 | 3 | 4 |	L. I adapt to new situations.
| 0 | 1 | 2 | 3 | 4 |	M. I initiate contact with friends, loved ones.
| 0 | 1 | 2 | 3 | 4 |	N. I show a sense of humor.
| 0 | 1 | 2 | 3 | 4 |	O. I am interested in future goals.
| 0 | 1 | 2 | 3 | 4 |	P. I pursue leisure activities.
| 0 | 1 | 2 | 3 | 4 |	Q. I exercise regularly.
| 0 | 1 | 2 | 3 | 4 |	R. I take sensible protective measures inside and outside house.
| 0 | 1 | 2 | 3 | 4 |	S. I choose supportive relationships over non-supportive ones.
| 0 | 1 | 2 | 3 | 4 |	T. I am able to relax without drugs or alcohol.

| 0 | 1 | 2 | 3 | 4 | U. I seem to tolerate constructive criticism well.

| 0 | 1 | 2 | 3 | 4 | V. I seem to accept praise well. I thank the person giving the praise.

| 0 | 1 | 2 | 3 | 4 | W. I enjoy a healthy sexual relationship. I can give and accept intimacy.

| 0 | 1 | 2 | 3 | 4 | X. I have long term friendships.

| 0 | 1 | 2 | 3 | 4 | Y. I am satisfied with relationship with spouse or partner.

| 0 | 1 | 2 | 3 | 4 | Z. My partner or spouse would say that our relationship is healthy and satisfying.

OTHER SIGNS OF RECOVERY (Please list any which are important to you):

| 0 | 1 | 2 | 3 | 4 | AA. My dreams are usually tolerable and not very upsetting.

| 0 | 1 | 2 | 3 | 4 | BB. My attention span is fairly good and I can concentrate well.

| 0 | 1 | 2 | 3 | 4 | CC. I experience a wide range of emotions, both pleasant and unpleasant.

| 0 | 1 | 2 | 3 | 4 | DD. People would say I am more calm than jumpy

List any others below:

| 0 | 1 | 2 | 3 | 4 | _____

| 0 | 1 | 2 | 3 | 4 | _____

| 0 | 1 | 2 | 3 | 4 | _____

| 0 | 1 | 2 | 3 | 4 | _____

| 0 | 1 | 2 | 3 | 4 | _____

| 0 | 1 | 2 | 3 | 4 | _____

Solution-Focused measures of recovery: An assessment approach for working with traumatised refugees

	Never	Rarely	Some-times	Often	Always
1. I am able to think about the traumatic events in my past.					
2. I have times when I do not think about the traumatic events in my past.					
3. I am able to think about other things than the past traumatic events					
4. When I think about the traumatic experiences in my past I know these things are not my fault					
5. I am able to settle myself after experiencing or remembering distressing thoughts and images					
6. I am able to tolerate radio, TV or newspaper reports of traumatic events from my country of origin					
7. There are times when I can relax					
8. I am able to cope with my feelings of loss					
9. I feel I have coped as well as possible with all the problems I have faced					
10. I am able to accept that I/we have left my country of origin					
11. I am able to acknowledge and express that I miss my family, friends and way of life from my own country					
12. My attention span is fairly good					
13. I am able to concentrate on daily tasks and complete them					
14. I am able to fall asleep within a reasonable time when I want to					
15. When I sleep I feel rested					
16. I eat well and healthily					
17. I am comfortable with my use of tea, coffee, sweets, alcohol and other stimulants					
18. I am comfortable with being alone					
19. I have a sense of humour and can laugh at things					
20. I am able to participate in activities I enjoy					
21. I am able to give physical affection					
22. I am able to enjoy a healthy sexual relationship					
23. I have friends who I spend time with					
24. I am able to cope with the physical pain that I experience					
25. I am receiving the assistance I need to settle in this country					
26. I am able to state my needs to people providing services to me					
27. I have some idea about what I want to achieve with my life here in Australia					
28. I feel I could build a new life for myself and my family here in this country.					
29. I am able to see life as meaningful					
30.					

Turnell, A. (2007). Thinking and practicing beyond the therapy room: Solution-focused Brief Therapy, Trauma & Child Protection. In T. Nelson & F. Thomas (Eds). *Handbook of Solution-Focused Brief Therapy: Clinical Applications.* NY: Haworth.

Solution-Focused scale for alcohol use

Name: …….. Date: ……

Please answer all questions. For each statement, indicate the degree to which it applies to you.

		Seldom	Sometimes	Pretty much	Very much
I.	**Skill Level**				
	1. I eat while I am drinking				
	2. I have no more than 4 drinks per occasion				
	3. I have no more than 20 drinks per week				
	4. I monitor my drinking				
	5. I measure each drink				
	6. I space my drinks				
	7. I dilute my drinks				
	8. I sip my drinks slowly				
II.	**Internal controls**				
	1. I handle social pressure to drink				
	2. I drink without physical problems				
	3. I feel comfortable discussing drinking				
	4. I sometimes overcome the urge to drink				
	5. I analyse my "slip ups"				
	6. I can stop after 1 or 2 drinks				
III.	**External controls**				
	1. I drink with other people				
	2. I have friends who do not drink				
	3. My spouse./family support my goal				
	4. I exercise regularly				
	5. I engage in social activities sober				
	6. I plan for drinking occasions				
IV.	**Coping statements**				
	1. I feel great in the morning				
	2. It is easy for me to relax				
	3. I sleep well at night				
	4. I can enjoy myself while sober				
	5. My spouse/family is proud of me				
	6. I take life one day at a time				
V.	**Self esteem**				
	1. I feel I am a likeable person				
	2. My friends think highly of me				
	3. Other people like to talk to me				
	4. I feel I am a good person				
	5. I have a good sense of humour				
	6. I feel proud not drinking				
	7. I feel confident about myself				
	8. People have a good time with me				

(From Brett Brasher. Based on Dolan, 1991.)

