Solution-Focused Therapy
For Patients’ Psychosocial Problems

Ronald E. Warner, EdD, CPsych
Vincent H.K. Poon, MD, PsyD, DMin, CCFP, FCFP

The Working With Families Institute, Department of Family & Community Medicine, University of Toronto
In today’s world, families are under increasing stress, from financial and time constraints, to family breakdown, substance abuse, and threats of violence. Family physicians are seeing an increase in psychosocial issues such as anxiety and stress-related disorders, often co-existing with and complicating medical problems such as diabetes or pneumonia. The psychosocial issues are often more difficult to diagnose and manage than are the medical problems—and all take place in the family context. Very often, the family is the key to dealing effectively with the whole spectrum of complaints, requiring a psychosocial assessment. In the crowded family medicine curriculum, this vital area of knowledge and skill is often ignored in favour of more clear-cut procedural skills.

To educate family physicians about dealing with families, a group of family medicine educators, practitioners and mental health professionals affiliated with the Department of Family and Community Medicine at the University Of Toronto founded the Working with Families Institute (WWFI) in 1985. The WWFI has developed various training experiences for trainees and practising physicians.

Goals
The goal of these modules is to provide a learning resource for physicians dealing with common medical and psychosocial issues that have an impact on families. The modules seek to bridge the gap between current and best practice, and provide opportunities for physicians to enhance or change their approach to a particular clinical problem.

The modules have been written by a multidisciplinary team from the Faculty of Medicine, University of Toronto. Each module has been peer-reviewed by external reviewers from academic family medicine centres across Canada. The approach is systemic, emphasizing the interconnectedness of family and personal issues and how these factors may help or hinder the medical problems. The topics range from postpartum adjustment to the dying patient, using a problem-based style and real case scenarios that pose questions to the reader. The cases are followed by an information section based on the latest evidence, case commentaries, references and resources.

How to Use the Modules
The modules are designed for either individual learning or small group discussion. We recommend that readers attempt to answer the questions in the case scenarios before reviewing the case commentaries or reading the information section.

The editors welcome feedback on these modules and suggestions for other modules. Feedback can be directed to Dr. Watson at dfcm.wwfi@utoronto.ca.

Acknowledgements
The WWFI is grateful to the Counselling Foundation of Canada for its generous educational grant in support of this project. The editors also thank Iveta Lewis (Librarian-DFCM) Brian Da Silva (IT consultant-DFCM), and Danielle Wintrip (Communications Coordinator-DFCM) for their valuable contributions to this project.

In addition, we thank our editorial advisory group including Ian Waters, MSW, Peter Selby MD, Margaret McCaffery, and William Watson, MD.

We also acknowledge the work of the Practice-based Small Group Learning Program of the Foundation for Medical Practice Education, on which these modules are modelled.

Bill Watson
Margaret McCaffery
Toronto, 2015
Solution-Focused Therapy For Patients’ Psychosocial Problems

Authors:

Ronald E. Warner, EdD, CPsych
Clinical psychologist, director of the certificate program in Solution-Focused Counselling, Faculty of Social Work, University of Toronto

Vincent H.K. Poon, MD, PsyD, DMin, CCFP, FCFP
Family physician, assistant professor, Department of Family and Community Medicine, University of Toronto; professor of counselling, Tyndale Seminary

Reviewers:

Schoel Shuster, MSW
Social worker, St. James Town Health Centre, St. Michael’s Hospital, Toronto; lecturer, Department of Family & Community Medicine, University of Toronto

Ian Waters, MSW
Social worker and professional practice leader, Department of Family & Community Medicine, Toronto Western Hospital at the University Health Network; and assistant professor, Department of Family & Community Medicine, University of Toronto

Lindsay Watson, MA, RMFT, marriage and family therapist, lecturer, Department of Family & Community Medicine, University of Toronto

Editors:

William J. Watson, MD, CCFP, FCFP
Margaret McCaffery, Canterbury Communications

Working With Families Institute, 2014

Chair: William J. Watson, MD, CCFP, FCFP
Associate Professor, Department of Family & Community Medicine and Dalla Lana School of Public Health
University of Toronto
## CONTENTS

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>SUMMARY</td>
<td>5</td>
</tr>
<tr>
<td>OBJECTIVES</td>
<td>5</td>
</tr>
<tr>
<td>Key Features</td>
<td>5</td>
</tr>
<tr>
<td>Core Competencies</td>
<td>5</td>
</tr>
<tr>
<td>CASE STUDIES</td>
<td>6</td>
</tr>
<tr>
<td>INFORMATION POINTS</td>
<td>8</td>
</tr>
<tr>
<td>Basic concepts of solution-focused therapy</td>
<td>8</td>
</tr>
<tr>
<td>Preparation for asking solution-focused questions</td>
<td>8</td>
</tr>
<tr>
<td>Solution-building questions</td>
<td>9</td>
</tr>
<tr>
<td>CASE COMMENTARIES</td>
<td>12</td>
</tr>
<tr>
<td>REFERENCES</td>
<td>15</td>
</tr>
</tbody>
</table>
SUMMARY

Ever since the 1980s, the importance of patient- and family-centred care has been recognized in family practice. Sobel indicated that when patients presented with one of the 14 symptoms most common in outpatient clinics (e.g., headache, chest pain, fatigue), a probable cause was established in less than 16% of cases. In this biopsychosocial and cultural context, counselling has become an inevitable component of family practice. Poon describes counselling as the process of helping people overcome obstacles to their personal and interpersonal growth and achieve optimum development of their personal resources and goals in life. Among the many approaches to counselling and psychotherapy, solution-focused therapy is most suitable for family physicians for the following reasons: it is brief, usually consisting of fewer than five sessions; it involves an intermediate (15-30 minutes) to advanced (30-60 minutes) level of counselling and thus is adaptable within family practice, and it is relatively easy to learn. This module provides an overview of the essential elements of solution-focused therapy, with an emphasis on working with families. The case examples illustrate how solution-focused therapy is used in the family practice setting.

OBJECTIVES

After completing this module, you will:
1. have a clear understanding of the basic concepts of solution-focused therapy (SFT).
2. be able to conduct SFT in daily practice.
3. understand the difference between problem-focused, symptom-based interventions and solution-focused, strength-based questions.
4. be able to co-construct practical solution-focused goals based on patients’ strengths, resources, motivation, and preferred future.

Key Features

1. SFT is a practical, brief method of counselling/psychotherapy that can be useful for family physicians to learn, in order to help their patients.
2. SFT is based on the principle of self-change, emphasizing strengths and competencies rather than weaknesses and deficits.

Core Competencies

1. Display effective, professional and non-judgmental communication skills
2. Adopt a patient centered approach
3. Demonstrate an effective approach to the presentation of illnesses with a strong psychological component
4. Demonstrate a willingness to build therapeutic relationships with patients presenting with psychological and psychosomatic illnesses
CASE STUDY

Case 1: Mr. K., aged 36

Mr. K. is a married factory worker. He has an ongoing drinking problem, which is affecting his job and his relationship with his wife. Previously you counselled him about his drinking, and he tried to quit. After a brief period of abstinence, he got drunk, stayed out until early morning, and missed work the next day. Today he has come to get a note for his employer. He wants the note to state that he was absent because of illness.

• What would you say to Mr. K.?
• How would you try to help him with the drinking problem?
• Would you feel frustrated that he did not follow your advice to abstain from alcohol?

Case 2: Mrs. G., aged 40

Mrs. G. has been married for 12 years. You have been her family physician (FP) for the past two years. Recently she has been suffering from frequent headaches. Your physical examination and basic investigations have found nothing abnormal. During the previous visit, you explored sources of stress that might be contributing to her headaches. She stated that perhaps the headaches were related to her unhappy marital relationship. You decided that scheduling a longer appointment to deal with this issue was appropriate. Today she comes in for the appointment.

• What would you say to Mrs. G. today?
• How would you try to help her?
• Where and how would you start?
• What intervention methods would you use?

Case 3: The W. family

Ruhamah is 15 years old. Her sister, Doreen, is a 20-year-old, second-year university student. They live with their parents and share a bedroom. However, they are not on very good terms with each other. Because you are the FP, the parents have talked to you about helping the sisters. You have convened a meeting with the four family members.

• How would you approach the subject of the sisters’ relationship?
• What technique might you employ to engage the two sisters in discussion with each other?
• How would you work on their relationship?

Case 4: Mr. J.

Mr. J., who has been diagnosed and treated for post-traumatic stress disorder, saw you three weeks ago, accompanied by his wife. He complained of a high stress workplace situation and his wife described how his moods had changed. You gave him a letter to the employer recommending that his work load be reduced and for Mr. J. to report back in a month. Now Mrs. J. phones and says they are in crisis—yesterday her husband walked off his job and is reluctant to
return. She pleads to see you urgently; you agree to meet with them in the afternoon.

- *How would you deal with this crisis?*
- *How would you move them from problem focused to solution focused?*
- *How do you co-construct goals with them?*
1. Basic concepts of solution-focused therapy

Developed by deShazer, Berg, and colleagues at the Milwaukee Brief Family Therapy Center, SFT employs strategies of personal empowerment. These strategies are designed to help patients discover and learn how to use their own strengths and resources. An assumption of SFT is that psychological change is essentially self-change and self-healing, which occur more quickly and effectively when the change process (consultation) emphasizes strengths rather than weaknesses, competencies rather than deficits, and possibilities rather than limitations.

According to this approach, all that is necessary for patient change is collaboratively discovering what the patient wants and which of the patient’s strengths and resources can be marshalled to achieve these goals. Because SFT focuses only on finding solutions, it does not emphasize the past or knowing the intricacies of the problems. The physician’s role is to help patients develop new solutions. Thus, all interventions involve using solution-building questions to engage patients in finding answers to their problems.

Outcome studies indicate that 72-82% of SFT clients benefit from therapy. This approach is now listed in the U.S. government’s National Registry of Evidence-Based Programs and Practices.

2. Preparation for asking solution-focused questions

To engage the patient in solution-building, one must understand and implement the following three conditions and strategies:

Rapport establishment—facilitating a positive alliance: The stronger the positive alliance, the more likely the effectiveness of solution-focused interventions. The goal is for patients to experience that their physician understands them, their feelings, and their problems. The issue is not whether the physician understands the situation—that is rarely sufficient—but whether the patient feels understood.

Strengths and resources—identifying and complimenting: One of the most effective ways to help patients develop solutions to problems is to emphasize their strengths or competencies, including personal resources. This approach is often described as “strength based,” and is founded on the ageless principle that the most effective learning and change occur by “accentuating the positive.” In an interview for example, listening very carefully to identify at least one patient strength related to the presenting concerns, and of reinforcing this strength is critically important. Listening and reinforcement are important whether the consultation is five or 50 minutes in length.

Feelings and negative emotions—acknowledging and validating only: With most counselling approaches, asking about and exploring feelings, negative emotions, and problem situations are essential. This strategy is based on the premise that before a patient can be helped, the practitioner must determine what is wrong or at least gain some understanding of the problem or behaviour;
this determination is facilitated by exploring feelings. With the SFT model, however, patients’ feelings and negative emotions (i.e., “what’s wrong”) are acknowledged and validated, but not explored and expanded upon. The challenge in SFT is to refrain from actively exploring patients’ feelings and problems, and to be guided by “what’s wanted” (solution-building) rather than “what’s wrong” (problem-solving).

3. Solution-building questions
The four most commonly used techniques and questions, and provides examples of physician solution-building responses:

Coping questions: In SFT, when clients experience trauma, major setbacks, or even little or no progress and feel discouraged, asking coping questions is usually helpful. This is an attempt to reframe the situation and gain a more useful perspective. The goal of such questions is to help patients discover their own resources and strengths that they do not know they have. With these questions, the physician affirms the patient’s dire state. Then the physician inquires how the patient keeps going in life (i.e., copes and manages). Once the patient is able to respond and show how they cope, the physician can move on and ask what it would take to continue doing what works. This is building on the patient’s own strengths.

Coping questions include the following:
• How do you cope with life despite all the difficulties you are experiencing?
• What is the one thing that keeps you going?
• What would it take for you to continue doing what you have done well?

Exceptions to the problem questions—discovering competencies: No matter how distressing and pervasive, no personal problem is experienced 24 hours a day, seven days a week. After acknowledging and validating the problem/distressing situation, inquire about the times when the problem is absent or at least affects the patient less, and explore in minute detail what is different about those times. Careful observation and persistence often uncover strengths that will help the patient resolve or better manage distressing situations.

Berg suggests that patients describe two types of exceptions: deliberate and random. A patient is able to describe a deliberate exception in a step-by-step manner. When this happens, the physician can encourage the patient to take more of the same steps in the future.

Exceptions questions include the following:
• Tell me the times when you do not experience your problem.
• What and how were you different when you did not have the problem? Please describe that in detail.
• When the problem did not happen, what was your situation like? How did you and others respond differently? What things do you think contributed to a different outcome?
Preferred (healthy) future—outcome or miracle questions: One of the most powerful SFT techniques is the outcome question: asking patients to think about the future when the problem situation (which they brought to you) is resolved, and obtaining details on what difference that will make in their lives. In situations in which resolution is not possible, the question may be worded as follows, or similarly:

- When you can handle this situation as well as is humanly possible, how will your life be better?

The best well-known outcome technique is the miracle question, which essentially involves a mild hypnotic induction procedure. This procedure is an attempt to bypass logical problem-solving thought processes. It is a goal-setting and solution-finding technique, and helps patients specify how things will be different once the problem is solved.

The following is a typical miracle question:

- When you go home and go to sleep tonight, suppose a miracle happens and the problem that has been troubling you (whatever the patient has been discussing) is gone—just like that! When you wake up in the morning, how will you know (or what will be the first clue) that a miracle happened last night?

The patient’s answers will serve as a road map for him or her to move forward. The physician will try to encourage the patient to move along this desired path.

Scaling questions—measuring progress: Scaling questions are used when change is required in human experiences that is not easily observed (e.g., feelings, moods, and communication). Patients are asked to rate on a scale of 1 to 10 some variable relevant to their presenting concerns (e.g., degree of pain or distress, willingness to comply, confidence, hope for the future, motivation to change). The number “1” always represents the worst that “things” (pain, despair, etc.) have been, and “10” represents the resolution of the problem or the achievement of a goal. In situations in which resolution is not or may not be possible (e.g., when a loss has occurred), “10” indicates that the patient is handling the situation as well as is humanly possible. Whatever number the patient selects, two further questions are asked:

- How did you get to that number?
- What would have to happen to increase the number on that scale by a point?

The following are the basic scaling questions:

- On a scale of 1 to 10, with “1” being the least of the quality considered, and “10” being the greatest, where would you put yourself/the present situation?
- What do you suppose your spouse/child would say on this scale?
- What do you suppose are the reasons you/other family members gave yourself/themselves that score on the scale?
- What would be different in your life/relationship if you moved up just one point on that scale?
- What do you think you need to do to move up one point on the scale?
• How would you like to try some of the above things so that you can move up one point on the scale?
• What do you think your spouse/other family member would say he or she needs to do to help you move up one point on the scale?
• How would you like to help your family member by trying some of the above things so that your family member can move up one point on the scale?

10. Post-traumatic Growth (PTG):
One of the newest SFT applications is in trauma treatment $^{16,17}$ by targeting one or more of the five Post-Traumatic Growth Inventory factors (greater appreciation of life, improved relationships, new opportunities, increased personal strength, and deeper understanding of spiritual matters).$^{18}$ One approach to using SFT with individuals, families, and groups is to have the patients rate each of these PTG factors on a five point scale, and have a detailed discussion of their highest factor.$^{15}$ In one of the author’s experience (RW) working with traumatized soldiers and their partners at Canadian Forces Base Kingston, this simple exercise was often the beginning of a transformative experience. This approach to trauma, using SFT to target PTG factors, has been gaining interest among members of several professional organizations. $^{19,23}$
CASE COMMENTARIES

Case 1: Mr. K., aged 36
You have seen this patient several times in the past and have talked to him about cutting down on his drinking. However, that approach seems not to have worked. Now the problem has progressed to the extent that it is affecting both his work and his marriage.

You have several options when you see him in your office. You can just ignore the problem. You can try to talk to him about the damage he has done to himself and his marriage. You can try to reassure him that the problem is not that bad and perhaps will not happen again. Or you may want to use the coping questions suggested.

If you try the coping questions, you will talk to Mr. K. in the following way:
- “I can certainly understand why you are feeling so discouraged after all that hard work staying on the wagon—three whole months! But I am really curious: How did you manage to stop drinking after only one night? The last time you drank you didn’t stop for three days! So what have you learned from this relapse that will help you next time you have an argument with your wife and feel the urge to drink? I would be interested to know how you would like to handle yourself the next time you and your wife get into a big argument.”

Case 2: Mrs. G., aged 40
You have decided that you would like to use SFT for Mrs. G. and her husband. You could start the conversation in this way:
- “Mrs. G., all the tests have come back negative, so with your agreement I would like to try something different. I would like you to pay attention to those times or days when the headache is not there. Mrs. G., could you do that tell me about the times when the headache is not bothering you or at least is not preventing you from working and doing other things that you like? Mr. G., could you help your wife do this, perhaps by keeping a record? I would like to know what is happening, what particularly is different about these headache-free times. At our next appointment we will discuss this. Any questions? Are you both clear on what we are going to do?”

Or you could use the miracle question with this couple:
- “Mrs. G., suppose a miracle happens and your headache is solved overnight. The next morning, what do you think you will notice that is different? What will let you know that there has been a miracle overnight? What is the first change you will notice yourself? What will your husband notice that is different about you? How would your husband’s behaviour be affected by the difference? What would you do differently then?”
You would ask the husband the same miracle question, and compare the answers. Their responses might lead you to ask follow-up questions to encourage both of them to realize the changes. You might want to ask each of them to start taking small steps so that the changes can be realized.

**Case 3: The W. family**

As the W. family’s FP, you have decided to try the scaling technique to help the two sisters get along better. First you ask Ruhamah where she is in terms of her relationship with Doreen. Specifically, you ask her to rate the relationship on a scale of 1 to 10, where “1” represents the worst the relationship has been and “10” represents both of them getting along very well. Her answer is “3.” You ask Doreen the same question; her answer is “3 to 4.” Then you ask each where they want the relationship to be on that scale. Both indicate several points higher. You respond:

- “Really! You both want a better relationship—is that right? Mom and Dad, were you aware—or are you surprised—that the sisters want a better relationship?”

The rest of the conversation goes as follows:

**You:** Okay, I see that there is a consensus in your family that everyone wants the relationship between the two sisters to be better. I would like to ask both of you sisters a tough question about your future. When both of you move up one notch on this scale, what will be different in your lives?

**Ruhamah:** I will be less grumpy, and not so miserable.

**Doreen:** I think I will be less irritable and enjoy the family more.

**Parents:** We will be very thankful that there is more peace at home.

**You:** Ruhamah, what do you think you can do differently so that there is a good possibility that you will be less grumpy and miserable? Doreen, what about you? What do you think you are willing to do differently so that you will be less irritable and find more enjoyment in living with your sister? Dad and Mom, what do you think are each girl’s strengths, which will contribute to their making these changes, and help make your home more peaceful?

After listening to their individual responses, you conclude:

- “I am very impressed by how each of you cares about the others and is willing to invest in this family. Each of you has very good suggestions. What would you say about trying these out in the next two weeks? Then you can come back and tell me what you have observed that is different in the family.”

**Case 4: Mr. J.**

When Mr. J. arrives, accompanied by his wife, he explains that he has been suffering from panic attacks and the last one was a few months ago when he had to walk off the job (“I just had to get out of there”) without saying anything to anyone. When he got home and settled down, he was able to phone his boss (at the urging of wife). The boss told him to take the next day off and report back to
work the following Monday. Mr J. says that he felt so embarrassed and humiliated, particularly about facing his workmates that he did not know how he could return to work.

There are several questions about strengths and resources that are apparent. Before continuing to read, how many can you identify? Here are some examples of solution-focused questions:

- “The first panic attack in a year! That is a long time – how did you manage that? How were the last three weeks on the job? I assume there were other times during those three weeks that you felt like walking away from the job but didn’t. What stopped you? What helped you overcome your embarrassment to call your boss? It appears that you have a very supportive relationship with your wife. Is that right? Is that what helped you to make that difficult call to your boss? How so?”

You decide to start the conversation in this way:

- “I can see how disappointed you are, Mr J. (long pause), but I am curious – how did you manage the stresses for over three weeks? – is that right Mrs. J.? ” Both nod and she adds that things have been better at home too: after the PTSD diagnosis they began talking more than they ever have. Mr. J. and wife appear more relaxed, look at each other more, and even sound a little bit hopeful. After about five minutes of discussion about how he managed to last over three weeks on the job, and obtain all the details of how the communication at home has improved, you decide to ask a goal question.

- “So it appears that your preference is to return to the job, but it is the embarrassment of having to face your workmates that makes it hard for you. Is that right?” He nods and gives more details about feeling embarrassed. “I hear you (long pause), but I wonder what would have to change or happen for you to report Monday morning and face your workmates? (long pause) I wonder what you could say to them that would make it easier on you?” After a long pause, when his wife makes a suggestion on what he might say, he takes a deep breath and says: “I got to go back—I can do it”. And you say, “Good, I think it is the best decision right now, and with the support of your wife, you can face this situation and not let these feelings of embarrassment” prevent you from doing the right thing. Do you agree? (He nods and thanks you.)
REFERENCES


