Solution Focused Interactions in Nursing

Solution Focused Interactions in Nursing:

Growth and Change

By

S.W. Smith

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With love to Kate, Keenan, Emily and Sarah.

TABLE OF CONTENTS

LIST OF TABLES

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CHAPTER ONE

INTRODUCTION

Why this book is important

I'm a nurse, I have been a nurse for almost all my adult life and I believe that nurses make a difference to people's lives. To the general public we are almost invisible; sure, they hold us in fairly high regard if asked, but for most of the time we're very much in the background. But, when someone is injured or ill, it is most often nurses that they reach out to, and it's nurses who can make a difference. I think this book is important, but then I wrote it so you would probably expect me to say that; so, let me try and explain to you why I think this book is important.

Nursing is about "growth"; at its heart it is about providing the conditions and environment in which another person can thrive. In the United Kingdom the Nursing and Midwifery Council (NMC) identified seven platforms which describe the core roles and responsibilities of a Registered Nurse (NMC 2018). They identified these platforms as:

1. Being an accountable professional
2. Promoting health and preventing ill health
3. Assessing needs and planning care
4. Providing and evaluating care
5. Leading and managing nursing care and working in teams
6. Improving safety and quality of care
7. Coordinating care

It can be seen that the first platform provides the basis for identifying Nursing as an accountable profession and therefore validates the role of the NMC. Platform 2, then, outlines the key roles and functions of a nurse, while platforms 3 and 4 develop this in terms of their respective remits. Platforms 5, 6 and 7 then describe the nurse's role as a manager and coordinator of care. So, it's platform 2 that cuts to the core of what it is to practice nursing. In the introduction to this section, the NMC state

> "Registered nurses play a key role in *improving* and maintaining the mental, physical and behavioural health and well-being of people, families, communities and populations. They support and *enable* people at all stages of life and in all care settings to make informed choices about how to manage health challenges in order to *maximise* their quality of life and *improve* health outcomes. They are actively involved in the prevention of and protection against disease and ill health and engage in public health, community development and global health agendas, and in the reduction of health inequalities."
>
> (NMC 2018a, 10)

I have added italics to those words which resonate most strongly with the idea of growth, but it seems clear from the passage above that the key role of a nurse is to help the person they are caring for to develop, improve and maximise their potential in spite of whatever health challenges that person may be experiencing.

Equally, the International Council of Nurses (ICN) also provide a core definition of what it is to be a nurse.

> The unique function of nurses in caring for individuals, sick or well, is to assess their responses to their health status and to *assist them* in the performance of those activities *contributing to health* or *recovery* or to *dignified death* that they would perform unaided if they had the necessary strength, will, or knowledge and to do this in such a way as to help them *gain full or partial independence* as rapidly as possible [Henderson 1977, 4].
>
> (ICN 2019)

Again, I have placed italics on the words and phrases that highlight the role of the nurse in helping the other person grow and to become all that they can be. The nurse nurtures the other person, cultivates their growth and nourishes them in order that they may grow and become, in some way, healthier. Indeed, the word "nurse" has its roots in the act of a mother (or another proxy mother, such as a wet nurse) feeding an infant, providing it with nourishment in order that it may grow and develop as an independent being.

While the role of the nurse has changed almost beyond recognition since the days of Florence Nightingale, nurturing "growth" has always been at the heart of the practice of nursing. Nightingale alluded to this in 1860 when she wrote,

> "I use the word nursing for want of a better. It has been limited to signify little more than the administration of medicines and the application of poultices. It ought to signify the proper use of fresh air, light, warmth,

> cleanliness, quiet, and the proper selection and administration of diet-all at the least expense of vital power to the patient."
>
> (Nightingale [1860] 2000, 8)

Although we may not apply many poultices in the health care environment of 21st Century nursing practice, there remains a bias of interest towards "the administration of medicines" and the other medically derived techniques that inform the advancing role of nurses, at the expense of those techniques that are at the heart of nursing itself. It is difficult to define; Carl Rogers, the author of what we now call *Person Centred Care*, showed that growth requires nurturing (Rogers 1957). Although Rogers was writing in the context of psychological therapy, like his concept of Person Centred Care the principles he advanced apply to all fields of nursing. He highlighted the importance of *congruence* (this could also be called genuineness or engagement), *unconditional positive regard* (this relates to caring for each individual unconditionally i.e. they don't have to earn our care) and *empathy* (being able to imagine what the other person *might* be experiencing). Indeed, a word that slipped into the previous sentence might be useful in describing (if not defining) what it is to "nurture growth", to engage with the heart of nursing; that word is "care". While "care" is possibly no easier to define than "nurturing growth", it is "caring" in this sense that lies at the heart of nursing practice. Without "caring", without this knowledge base from which we encourage another person to grow, we are left as mere *medical technicians* unfit to be called nurses.

In the context of nursing, *health* is about *change*. Change from a less healthy state to a more healthy state. Health, of course, is a complex idea; what do we mean when we speak of health? At its simplest level, for some people health could be defined as simply the absence of illness i.e. if you're not ill you're healthy! However, this definition is widely seen as being overly simplistic, and is expressly rejected by the World Health Organisation (WHO) who state in their constitution document,

> "Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity."
>
> (World Health Organisation 2006, 1)

This definition, though, is also not without problems. The WHO position health as an ideal state in which an individual has *complete* physical, mental and social well-being; however for many people, such as those with well-managed long term conditions, this is an unrealistic goal despite that fact that the individual may *feel* healthy. As far back as the 1980's, David Seedhouse was

arguing that health should be seen as a dynamic state of well-being relative to an individual's ability to achieve their potential.

> "A person's optimum state of health is equivalent to the state of the set of conditions which fulfil or enable a person to work to fulfil his or her realistic chosen and biological potentials. Some of these conditions are of the highest importance for all people. Others are variable dependent upon individual abilities and circumstances. The actual degree of health that a person has at a particular time depends upon the degree to which these conditions are realized in practice."
>
> (Seedhouse 1986, 61)

The psychologist Barbara Lehman argues that this form of biopsychosocial health model has come to dominate health psychology thinking in the past few decades, and along with her colleagues (Lehman, David and Gruber 2017) expands upon the tradition biopsychosocial model by suggesting the need to include what she terms "contextual dynamics" into the equation.

> "Specifically, contextual dynamics include broad patterns of shared culture, norms, policies, and values. These considerations not only help to shape interpersonal, psychological, and biological factors, but are in turn shaped by them."
>
> (Lehman, David and Gruber 2017, 5)

So, if we view *health* as a complex interplay between biological, psychological and social factors engaged in a reciprocal relationship with contextual dynamics, we can see that the concept of health is far from being a simple or straightforward idea. However, it becomes clear that any individual occupies a position on a spectrum between "good health" and "poor health", and that that position can *change* in relation to the interplay between these factors mentioned. It follows from this, then, that the nurse's role is to promote that change whenever it is possible, which begs the question, "and when is it not possible?"

One further factor to consider though is what the linguist Kenneth Pike termed the *emic* and *etic* perspectives. Although Pike used the terms in relation to linguistics, in healthcare terms the emic perspective relates to how the individual person perceives their own health status, while the etic perspective relates to how other people (especially professional services) see an individual's health status. Consider the way in which we as nurses might consider a thirty-year-old man who consumes two bottles of vodka a day to have a significant health problem (etic perspective), while that individual might tell us, "I'm fine, it doesn't do me any harm" (emic perspective). It's important to remember that while we may have a range of standardised tests

and statistics and a researched evidence base to support our etic perspective on someone else's health, if the person's emic perspective doesn't recognise a problem then they are unlikely to engage in any change based behaviour. Therefore, as nurses, it's not enough for us to have our own professional knowledge and understanding, we also have to engage with the other person's perspective (the emic perspective) in order to bring about change. But change is difficult; I remember hearing a joke once, "what's the last act of a desperate man?" the answer is "change". Solution Focused Interactions give us a framework within which we can encourage and enable another person to change without engaging their (entirely understandable) defences against being changed.

There is an old story, I think it was based on one of Aesop's fables, which demonstrates well the gentle way in which Solution Focused Interactions can help someone change.

The Sun and the Wind were up in the sky one day, and they got talking. The conversation got around to feats of strength and the Wind said that he was clearly stronger than the Sun. The Sun didn't accept this, "No, no; I'm much stronger than you are, you can't even see you!" However, the Wind argued back, "That's got nothing to do with it, I can blow down trees, and blow the roofs off of buildings and stuff like that". Back and forth the argument went until they decided to have a competition to see who was the stronger. "Right, see that man walking down the road there", said the Wind pointing at a man walking along the road, wrapped up in an overcoat and a hat, "let's see who can get that coat off him". The Sun agrees, and they agree that the Wind should go first. So, the wind gathers up his breath and bellows a great rush of wind down towards the man. Leaves blow along the ground, branches shake and the man tightens his coat around him and walks on a little bit faster than before. The Wind takes a second, even bigger, breath and blows a great gust at the man. His hat nearly blows off, he has to hold it on with his hand, and he holds the collar of his coat closed with the other hand. The wind takes a massive great breath, he's starting to go red in the face, and blasts a massive hurricane of wind at the poor man. The man is practically doubled over, walking slowly into the wind, coat wrapped round him, hat jammed on his head, fighting his way against the wind. Eventually the Wind says, "Okay, that's probably not the best kind of test, let's do something else", but the Sun says, "Hold on, I've not had my shot yet!" So, the Wind steps back, sniggering to himself and saying, "Well, I don't know what you're gonna do; if I can't beat him you never will". But the Sun steps forward and begins to beam down on the man, he pours warmth and sunshine down onto him, and before long the man starts to feel warm,

and then he starts to feel hot … and then he takes his coat off and puts it over his arm.

I think this illustrates that we can't *make* someone do something, but we can influence them in *wanting* to do something. In solution focused terms we often refer to this as "a nudge from behind", just a gentle prompt in a direction that will help the other person to want to go further in that direction and to change in some way. When someone wants to change towards a more healthy way of living, they have grown; it's the nurse's role to promote that growth.

I first became aware of the ideas underpinning Solution Focused Interactions back in the late 1980's. I was working in a large "psychiatric hospital" and was becoming increasingly interested in the work we were doing in small group, semi-interpretive, psychoanalysis. I had a friend who I had trained with, who was now working as a Community Mental Health Nurse in Family Therapy, and who began telling me about this new approach he had come across called Solution Focused Brief Therapy (SFBT). Graham and I would meet up once a month or so, have a couple of beers and usually end up talking about psychotherapy (we're still pretty much doing the same thing over thirty years later), and he was clearly very excited about this new approach he had been introduced to. Developed by a couple of family therapists, Steve de Shazer and Insoo Kim Berg, in Milwaukee, Wisconsin (De Shazer *et al* 1986), Graham described the therapy as "off the wall; you don't talk about problems at all, you focus on what the client wants their future to be like, you talk about miracles happening and all their problems are solved, how would they know that had happened!" For all Graham's enthusiasm, I was somewhat sceptical, being steeped at that time in Freudian analytic theory I argued that if you didn't address the underlying problem it would simply reappear in another part of the clients psyche at a later date. "That's just a theory", Graham argued, "It's not necessarily true. This is another theory, but it's more straightforward and it's got a lot of evidence that it works". I certainly wasn't convinced, but I had an open mind and over the next few years I came across a couple of references to SFBT and tucked them away at the back of my mind.

By 1994 I had also become a Community Mental Health Nurse working in Aberdeen in the North East of Scotland. I had the opportunity to attend a training workshop run by the *Solution Therapy Practice*, a group of practitioners based in Essex who had undertaken a six-month residency training with de Shazer and Berg at the *Brief Family Therapy Centre* in Milwaukee (Hawkes, Marsh and Wilgosh 1998). Dave Hawkes led the workshop and by the time I came out on the second day, I was convinced; "I GET IT!" I wanted to go and do further training, "Where do I go for the

diploma in this, where can I get a degree?" A bit of a search in my local hospital library, this was in the days before the internet, revealed there wasn't anywhere offering the training I was looking for (I later discovered that there was an excellent Masters course, led by Bill O'Connell, at the University of Birmingham), and so I had to piece together my training in SFBT myself. Harvey Ratner from the *Brief Therapy Practice*, for many years now known simply as BRIEF (see BRIEF 2018), brought Steve de Shazer up to Glasgow in 1996 and I had the amazing experience to be able to sit in a group of about twenty-five people and learn tips and techniques directly from one of the people who had developed the approach; something I wouldn't have been able to do if I'd stuck with the Freudian approach! I also attended a seminar with Scott Miller (see Miller n.d.) a couple of years later, and read everything I could find on SFBT at the hospital library and at the Robert Gordon University library where I had started doing a Bachelor's degree. My degree dissertation focused on using SFBT in the treatment of depression in older adults, and almost twenty years later my PhD focused on the impact training in SFBT has on nurses.

I was fortunate that I was able to practice, under appropriate supervision, SFBT almost every day in Aberdeen between 1996 and 1999. During this time colleagues would hear me talking at our regular multi-disciplinary team meetings, reporting back on client's progress, "He was able to describe a positive future scenario where he wasn't depressed and was doing *such-and-such* and *such-and-such*, he recognised that he'd actually been doing some of that recently, and he scaled himself at 6, which is up from 2 when I first met him three weeks ago". Colleagues began to ask, "What *is* this solution focused stuff you go on about?" and so, by the late 1990's I began to run two-day training workshops within the local hospital community. Finally, in 2005, I moved into academia full time and the following year developed the first degree level course in SFBT in Scotland. I had been working at RGU, on a part-time basis, since 1997 and so had some experience of the kind of feedback I usually got from students on courses that I delivered, and so I knew that the feedback I got from the first SFBT course in 2006 was unusually positive; it was all nurses, and almost all of them appeared to have loved the course. This feedback was repeated in 2007 and again in Aberdeen and Glasgow in 2008, and so in 2009 I began to formally research the experience of course participants as the basis for my Doctoral research. That research forms part of this book, and hopefully this brief account of my experience will explain some of why I want to write this book and share the benefits of working in a solution focused way.

Today, SFBT has developed and expanded into a broad range of contexts, no longer a therapeutic approach *per se*, the term Solution Focused Interactions

seems a more pertinent phrase in today's context. SFI can be found in all aspects of health care, social care, prison services and organisational communication (Iveson 2002, Trepper *et al*. 2006, Walsh 2006, McKergow and Bailey 2014), but this book focuses specifically on the use of SFI in nursing, not just Mental Health Nursing (there is a myth that SFI only has application in mental health settings-nothing could be further from the truth) but all domains of nursing practice: Adult, Children and Young People, Learning Disabilities, Mental Health, in community and hospital settings, as well as Midwifery and Health Visiting. Since the earliest days of SFBT, nurses such as Dana Hillyer, Denise Webster and Carol Montgomery (Webster 1990; Montgomery and Webster 1994; Hillyer 1996) in the United States, and Ron Wilgosh, Dave Hawkes and Deborah Sandeman (Wilgosh, Hawkes and Marsh 1994; Sandeman 1997) in the UK have argued that solution focused approaches are congruent with the values that underpin nursing practice. Almost thirty years ago Denise Webster argued that solution focused approaches reflected at least ten ethical principles of nursing including,

> "(1) being sensitive to individual and cultural differences, (2) preserving human dignity, (3) enhancing self-care abilities, (4) identifying and supporting clients' strengths, (5) focusing on health rather than pathology, (6) attempting to diminish pain, (7) focusing on reintegrating people into supportive social systems, (8) emphasizing the pragmatics-doing what works, (9) ensuring a climate of safety, and (10) mobilizing hope in clients."
> (Webster 1990, 17)

While most approaches and models of nursing care would argue that they too support these core ethical standards (indeed I have never yet come across an approach to nursing, or any other health and social care discipline, that argued *against* these principles), I would suggest that working within Solution Focused Interactions takes the degree of application of these principles to a whole new level. The guiding principles inherent in Solution Focused Brief Therapy also inform Solution Focused Interactions, and when Ron Wilgosh and colleagues (referring to SFBT) stated,

> "We feel released from the need inherent in other models of therapy to take responsibility for finding the solution on behalf of the client. Our previous orientations have often blinkered us so that all we could see were problems. There are more things to our clients than problems, incompetencies and weaknesses. Now we see strengths, resourcefulness, competence and humour. These are the building blocks to the client finding a solution."
> (Wilgosh, Hawkes and Marsh 1994, 21)

their comments apply equally well to Solution Focused Interactions. This book serves as an introduction, then, to how SFI can be used across nursing practice to help us help our patients to grow and change, and hopefully help us to grow and change too.

CHAPTER TWO

FAMILY TIES: SOLUTION FOCUSED BRIEF THERAPY

The roots of Solution Focused Interactions clearly lie in the development of Solution Focused Brief Therapy (SFBT), but what is less clear are the roots of SFBT itself. Although there is wide agreement in how *to do* SFBT, there is less agreement on *where* SFBT originated from. One of the founders of SFBT, Steve de Shazer, spoke about the philosophical roots of the approach being in the work of Jacques Lacan, Jacques Derrida and Ludwig Wittgenstein (de Shazer 1994) and has written widely about the clinical influence of practitioners such as Milton Erickson, John Weakland and Paul Watzlawick (de Shazer *et al* 1986, de Shazer 1994, de Shazer and Dolan 2007); however, little has been said about *how* these various factors came together, and what other factors influenced them. Indeed, de Shazer once described SFBT as "a rumour",

> "This essay treats solution-focused therapy as a rumor. Solution-focused therapy is a series of stories that members of diverse therapy communities tell one another."
>
> (Miller and de Shazer 1998, 363)

Various practitioners and teachers tell permutations of this story, there are probably as many subtly different stories as there are practitioners; the Scottish psychiatrist Dr Alasdair Macdonald gives a particularly good account in his book "Solution Focused Therapy: Theory, Practice and Research" (Macdonald 2011). The "version" of the story that I am telling here (or, if you like, the rumour that I am spreading) is the version I have been telling participants on my training courses for the past twenty years, it extends back over 2,500 years and expands on statements I heard from my teachers of SFBT and read in papers and books outlining the development of SFBT. The following quote from de Shazer and Dolan (2007) gives a flavour of these statements,

> "One can clearly see the roots of SFBT in the early work of the Mental Research Institute in Palo Alto and of Milton H. Erickson; in Wittgensteinian philosophy; and in Buddhist thought"
>
> (de Shazer and Dolan 2007, 1)

Although it is of interest to know that Erickson, Wittgenstein and the Buddha have all played a part in the development of SFBT, this does little to tell us *how* they have influenced that development. So, based on my reading and understanding, this is *my story* of the development of SFBT, it's not the only story out there, but it explains some of the key thinking that underpins solution focused therapy and practice. And so we begin, as promised, two-and-a-half thousand years ago with the Buddha.

The Buddha

SFBT isn't a religious practice, and you certainly don't have to be a Buddhist to practice in this way; the relevance of the Buddha here is less on his role as a religious leader and more on his role as a teacher and philosopher. Many of the things that the Buddha said have gone on to influence both Eastern and Western thought, and a few of these are particularly relevant to the development of SFBT.

One of the earliest things the Buddha taught was what has become known as The Four Noble Truths. The first of these Truths is called *Dukkha* in the Pali language of ancient India, and is usually translated as "All life is suffering". However, "suffering" is only one English word that conveys the meaning of "dukkha", another (and I would suggest better) word is "stress", and so we can translate the first Noble Truth as "All life is stressful", thinking of "stressful" as being "distressing" and "unsatisfactory". The Buddha goes on to explain that this stress is caused by our *clinging*, or *attachment*, to our ideals, to the way we think things should be as opposed to the way they actually are (this is the second Noble Truth-*Samudaya*). However, this stress caused by our attachment to ideals can be overcome by letting go of our attachment (the third Noble Truth-*Nirodha*) and following the Noble Eightfold Path (the fourth Noble Truth-*Marga*). The Noble Eightfold Path and such-like doesn't concern us here, what is important from a solution focused perspective is the observation that much (if not all) of our suffering is caused by our attachment to how we think things should be. Many times I have worked with people who believe that they cannot be *happy* (in whatever way that word has meaning for them) in the circumstances they find themselves in or, conversely, that they can only be happy if something specific happens. I'm thinking of situations where someone might tell me that they can't be happy because they have been

bereaved, or they have made a grave mistake in life (whether they have or haven't actually done this is generally irrelevant in a solution focused approach), or they have been diagnosed with a life-limiting condition; equally, situations where someone tells me that they cannot be happy unless their symptoms diminish, or they have a child, or they get a change in their current treatment plan apply in the same way. In all these situations the person has identified a "problem" or a "solution" (which is a reasonable thing to do) and then come to believe that this is the only perspective that exists (which, although common, is not a reasonable thing to do). So one of the central ideas of Solution Focused thinking is "*If it's not working, do something different"* (de Shazer and Dolan 2007, 2). Working with these people to explore the usefulness of their own particular perspective in terms of overcoming their problem (i.e. "getting better") can help them begin to take the very brave step of "letting go" of their current perspective and finding a new, more useful, way of looking at their situation. Note that this isn't about me "telling" the person that their perspective isn't working, it is much more often about me "listening" to the person and allowing them to explore their thinking and arrive at a more functional conclusion; it's a bit like the role of the sun in the fable in Chapter One, I'm not forcing the person to change, I'm simply making it easier for them to do so voluntarily. There will be more about how to actually do this in Chapter Three.

Following from the ideas around "attachment" and "letting go" is the idea of change. We looked, briefly, at change in Chapter One, and "change" is probably what solution focused practice (SFBT, SFI, solution focused anything) is all about. As I said in Chapter One, change is often seen as difficult (what's the last act of a desperate man?), but in Buddhist thinking, change is seen as the norm, change is seen as constant. Writing about this, Steve de Shazer tied this notion to Gregory Bateson's idea of *information* being "the difference that makes a difference" (Bateson 1979, 99):

> "this view seems related to a Buddhistic notion about change. For the Buddhist (Stcherbatsky, 1962) change is a continual process and stability is only an illusion or a memory of one moment during the process of change. Clearly, there are differences (changes) which make a difference, as well as changes that do *not* make a difference. In the latter case, some changes are not perceived as differences because they are too small or so slow that they contain no news of difference-the Buddhist illusion of stability."
>
> (de Shazer 1985, 78/79)

In solution focused thinking it is accepted that "change" is happening all the time, although we don't always realise it. This is for, at least, two reasons; first of all, the change might be too small for us to easily recognise

it, in the second case we may simply not be looking for that change-and therefore miss it. There was a quite remarkable experiment conducted by two psychologists, Christopher Chabris and Daniel Simons (Chabris and Simons 2011), in which they video recorded two groups of people (one wearing black tops and the other wearing white tops) passing a basket-ball back and forth. Observers were asked to count how many times the white team passed the ball to each other. This seems a relatively simple task and most observers managed to count the number of passes; however, while watching the video closely, very few observers noticed a person dressed in a gorilla costume walk into the middle of the experiment, beat its chest and walk off. I will confess that when I first saw the video I totally didn't see the "gorilla" walk onto the set or beat its chest, I only saw it mysteriously appear from behind one of the players and walk off the set to the left. What this shows us is that we, do indeed, only see what we expect to see unless the "difference" between what we expect to happen and what *actually happens* is really quite marked. From a solution focused perspective this means that when someone tells us that they are "always" sad, or worried, or in pain, we can make a fairly accurate assumption that, although that is genuinely how the person perceives their situation, a little gentle exploration may well reveal "exceptions" to this rule where the situation has been different. Even if the person cannot recall any time where there have been exceptions to their norm, we can assume that there "will be" some exceptions in the near future if the person is expecting to see them; this leads to another tenet of SFBT, "*No problem happens all the time; there are always exceptions that can be utilised"* (de Shazer and Dolan 2007, 3).

One further aspect of Buddhist teaching of relevance here is the Buddha's teaching that all of the problems of living, all the causes of our "suffering" (i.e. all the causes of our attachments) had been around for ever, and there was little point in trying to find out where they had arisen. It was much more worthwhile to learn how to overcome those problems. Indeed, the Buddha's last words to his followers, at his death, are reported to have been that they should not simply take his word for all the things he had told them, but they should find out "the truth" for themselves. This contains several points for solution focused practice. Firstly, it relates to the understanding that people have always had problems; there is little point in trying to understand why someone feels they will never be "complete" if they have a leg amputated, or unless they have a baby, it is enough to understand that that is how they currently feel, and then to work with them to challenge that belief in order that they can begin to find that sense of "completeness" having had their surgery or not having had a child. Secondly, this highlights the experimental nature of solution focused practice; each

individual is different, so there cannot be a "one-size fits all" answer. Solution focused interactions are tailor made to the individual, in SF terms we talk about "co-construction", I like to think in terms of "practitioner" and "participant" in highlighting the interplay between both people involved. So every time we begin working with someone new (and, indeed, while we are working with them) we take a "not-knowing" position (more about this in Chapter Three) and our suggestions are given as a sort of experiment for the patient to try out. It's a worthy reminder that we don't *know* what's going to help this person, but we can help build (co-construct) some ideas about what *might* help.

William of Ockham

William of Ockham (1287-1347) was a fourteenth century Franciscan monk who argued that in any form of discussion we should endeavour to keep our discussion as simple as possible. He is the father of the principle known as Ockham's Razor; obviously, as a fourteenth century monk, he wrote in Latin and therefore, as with the Buddha, we have the problem of translation, however, what he advocated can be translated as "That which is done with less is done in vain with more", another translation could be "Entities should not be multiplied beyond necessity". The essence of what he was saying is, basically, that the best arguments are the most straight-forward, the simplest, arguments. His position came from his experience of being an academic at the University of Oxford where there raged an argument concerning the nature of Mans' soul. On the one side was the orthodoxy who argued that Mans' soul was binary i.e. the *physical* and the *spiritual* aspects of the soul were two separate entities, while on the other side were the radical philosophers who argued that the soul was one, unified, entity containing both the physical and spiritual aspects of life. This debate, in the Fourteenth Century, became quite heated (quite literally, blood was spilled) and it was into this debate that William of Ockham asked the question, "If Mans' soul is made up of two distinct parts, how are they connected?" This brought the high philosophical argument down to a very basic, pragmatic, element, and a question that the traditionalists could not answer. William then argued that, if no one could explain how the two parts of the soul were connected, then it was safer to assume that the soul was made up of only one unified part. In essence, he argues that the simplest explanation which will explain a situation, while acknowledging all that is known about the subject, is usually the safest explanation to work with.

I once saw a very good example of this maxim while watching late night television. The programme was exploring the phenomena of "crop circles",

circular shapes that appear in fields of crops overnight and are thought, by some, to be signs of alien space craft visiting earth. However, the programme also interviewed a man called Doug Bower, an elderly gentleman from the south of England, who claimed that he and his friend, Dave Chorley, had created many of these circles following an evening in the pub in 1978 (see Brough 1991). He explained that they had been returning home, having had perhaps one-too-many, and had seen a beautiful corn field in the moonlight. As both men were artists, it didn't take them long before they were wondering if they could create something in the field of an artistic nature. Mr Bower went on to say that the two men had tied a length of rope onto either end of a piece of wood and had used this to crush down the corn in a circular motion, creating an interlinked series of "crop circles". The programme went on to interview several UFO-logists who were outraged that an elderly man was trying to claim credit for what they believed was the work of extra-terrestrial beings. Now, the origins of these "crop circles" clearly lies outside the scope of this book, but it is much more straight-forward to accept that two elderly men can have "a bit of a laugh" while creating a form of visual art using a piece of rope and a length of wood, than it is to accept that life exists on other planets in the galaxy, that these life forms choose to travel through space to get to Earth, where they then do whatever is required to make these shapes in fields, and then they leave again, all the while not being noticed by any of the organisations whose job it is to monitor our airspace. Without judging any of the assumptions required by either argument, it can be seen that the first argument requires far fewer assumptions than the second, and therefore, according to William of Ockham, is more likely to be correct.

The importance of this approach for Solution Focused Interactions lies in the fact that problems concerning human interactions tend to be unbelievably complex, and those of us in the helping professions have an unfortunate tendency to believe that we have to understand the problem in all its complexity before we can help the person with the problem. "Where did the problem come from?", "how is it maintained?", "what makes it worse?", "why is it a problem at this point in time?" these are just some of the questions that immediately come to mind for us when we are confronted with someone else's problem. Imagine a brief conversation between a patient and nurse on a typical hospital in-patient ward. The patient complains to the nurse that she can't sleep at night, and the nurse naturally asks why. The patient then says that she has pain in her lower back, she's also worried about her adult son who has recently lost his job, there's also a lot of coming and going in the ward at night, and the woman in the next bed snores loudly. She is also missing her cat. That gives the nurse a lot of genuine problems

to be solved; however, none of these things is actually the problem. The problem is that the patient "can't sleep at night" and if we focus on that we can often come to a solution without going through all the other problems which are connected to it. The nurse might ask, "What do you think would help you sleep at night?" to which the patient might say that she usually has a cup of Horlicks before going to bed. If the nurse can organise for her to have a cup of Horlicks before she settles for the night that may well solve the problem, and solve it quickly. What may have been a highly complex problem which took several days (and nights) to sort out is reduced to a simple solution by keeping the focus of the discussion as simple as possible and making as few assumptions about the problem as possible. By "keeping it simple" we "keep it brief" and, in an increasingly busy and stretched healthcare environment, brief successful patient-nurse interactions are clearly at a premium.

Ludwig Wittgenstein

Skipping forward some 500 years we come to another philosopher, Ludwig Wittgenstein (1889-1951). Wittgenstein was a major influence on Steve de Shazer's thinking in terms of language and the use of language. I remember one of my early teachers in Solution Focus Therapy (Dave Hawkes, as I recall) paraphrasing Wittgenstein and saying that we don't use language to describe reality, we use language to create reality; he went on to say that, in general, we don't have problems with life, we have problems with the words we use to describe life. There are two ways of looking at this; one way is to simply say that as we use language (words) to create reality (life) then any problems we have with reality are caused by the words we used to create that reality in the first place, this may well be true but many people will find it challenging. The second way of looking at the statements is to say that if we use words to describe/create reality then by changing the words we use we can change the reality of life as we experience it. Wittgenstein is often quoted as saying, "The limits of my language mean the limits of my world", which clearly implies that the scope of the world as we experience it is a direct product of the scope of the language we use to describe/create it. Unfortunately, although a quick search will produce multiple references to this quote, none that I have ever been able to find will provide a source i.e. did Wittgenstein ever really say this and, if so, where? Probably, this is a simplified version of something that Wittgenstein did actually say and, because it's more concise than the original it has become accepted as something like what Wittgenstein said. In the introduction to his book Tractatus Logico-Philosophicus Wittgenstein says,

> "[This] book will, therefore, draw a limit to thinking, or rather—not to thinking, but to the expression of thoughts; for, in order to draw a limit to thinking we should have to be able to think both sides of this limit (we should therefore have to be able to think what cannot be thought).
>
> The limit can, therefore, only be drawn in language and what lies on the other side of the limit will be simply nonsense."
>
> (p23)

Therefore, he argues that all that can be known, all that can be thought of, is expressed through language and so it follows that the limits of my language are the limits of my world. This has profound importance for SFI in that, if we use language to create the reality we experience then we can change that reality by using different language. Put simply, in SFI we use words to paint word pictures of positive future scenarios.

When I was very young there was a programme on the television called "Paint Along with Nancy". As far as I can remember, it was on in the afternoon in the mid-'70's and starred an American artist called Nancy Kominsky. She painted in oils with a palette knife and would explain what she was doing as she went along. I remember her saying on one occasion that you "begin with the background, painting in broad strokes" as she smeared large areas of canvas with bold colours. "Then you work on the middle distance, adding shade and colour, putting the main features of the painting in place. And then, before you finish, you add the details, because it's the detail that makes it real." And this is what we do in SFI; we ask the person we are talking to to paint a word picture, a richly detailed picture of what their future will be once their problem is gone. They might say, "Oh, I'll be happy", but that isn't going to help anyone; such a one-dimensional answer lacks any detail, it's never going to create a new reality, so we need a much more detailed description of what it means "to be happy". And so we ask the person we're talking to to describe what they will be like when they are happy, and in particular to describe it in behavioural terms, or observable terms; what will they be doing when they are happy, what will I notice different about them when they are happy? By focusing on these aspects we begin to paint a picture of a positive future scenario in which the person does not have the problem they are currently experiencing. And once we have begun to paint this picture we add depth and texture to it by asking for further details ("what else will be different?"). In this way we begin to build up layers and layers of detail, creating an alternative reality to the one the person has previously envisaged, i.e. we co-construct a positive future scenario as opposed to a negative future scenario, and we implicitly present the choice to the person we are working with. In almost all cases the person

will, understandably, choose the positive option and aim in the direction of the positive future they themselves have created.

Milton Erickson

Erickson (1901-1980) was a physician, psychiatrist and psychologist who spent most of his career as a hypnotherapist practising in Phoenix, Arizona. He is one of the most enigmatic figures in the development of solution focused interactions, and a major influence on Steve De Shazer's thinking. De Shazer described him as an almost mythical figure, "Erickson-the-Clever", who worked in the most unfathomable way to solve the most complex mysteries of human nature. Unfortunately, the way in which Erickson worked appears almost totally idiosyncratic; he drew upon everything he knew to help the patients and clients who consulted him, specifically he drew not only upon his education and training but his life experience, observations and the connections he made between them. This leads to two important points about Erickson: firstly, that attempting to study and emulate his "technique" is almost certainly impossible; his colleague and "disciple" Jay Haley said,

> Part of the problem when examining Erickson's therapeutic technique is the fact that there is no adequate theoretical framework available for describing it".
>
> (Haley 1967, 532)

His way of working with people is so personal that it cannot be understood by simply reading about it; you get the sense that you would have to live his life in order to practice his therapy, however that leads us to the second point. Erickson clearly used himself as a therapeutic agent; he wasn't someone who sat outside of the therapeutic relationship and "delivered" a therapy, he *was* the therapy, and this is something that is vastly important for us as nurses. Nursing is an interpersonal profession, we engage in interactions with patients, and to do that we must be skilled at making therapeutic use of our self. Knowing how to that is largely what this book is about.

There are many, many stories told about Milton Erickson, he seems to have been that kind of person. One story that has stuck in my mind is one that my earliest teacher, Dave Hawkes, told me. The story goes that one day a woman phoned Erickson's office and asked to make an appointment. She was asked if she could describe the problem she wished to discuss with Dr Erickson, however she declined to do so, saying that the problem was too embarrassing and she had probably made a mistake in calling. Fortunately,

she was put through to Erickson in his office and he asked her what the problem was, and again she said she couldn't possibly discuss it. Now, most people would probably accept that if the patient can't tell them what the problem is then they are unable to help them, but not Erickson. He asked the woman to drive to his home, where he had his office, and to park in his driveway. Once she had done that she was to sit in the car and imagine what it would be like to come into his office, sit down, and imagine what she would say to him. The she was to imagine what he would say to her that would be helpful, and what she would say in response. She was to imagine the entire conversation they might have that would be helpful for her. Then she was to start up the car and drive home again. Erickson then asked her if she would call him the day after this 'appointment', which she agreed to do. On the appointed day she duly drove up to his driveway, sat in the car for half an hour or so, and then drove away again. Next day she called; Erickson commented that he had seen her from the window the previous day and asked if the visit had been helpful, the woman enthusiastically stated that it had been very helpful. Erickson asked her to scale how helpful it had been, 0 was where she had been when she had called his office and 10 is where she will be when she doesn't need to see him anymore. The woman reported that she had improved a bit and was now at 2. Erickson complemented her on being able to make that achievement and invited her to come in for another session in a week's time; however, the woman still felt unable to discuss her problem with him and declined. Erickson, therefore, suggested that she come back and once again sit in the car and imagine what she would say. The following week the same scenario ensued and the next day the woman called. She was very pleased to report that she had found the imagined conversation very helpful again, and was now at a 4 on Erickson's scale, but she still couldn't face speaking to him about her problem. To cut a long story short, the woman repeated these visits a few more times and on each occasion sat in the car and imagined what Dr Erickson would say that would be helpful to her, and how she would respond to him. On her final phone call she stated that these visits had been life changing and scaled herself at 8 on the scale Erickson had described previously. He again invited her to come to a more traditional appointment in his office, to which she responded that she didn't have to do that as she now felt able to deal with the problem herself. There are several important points in this story in relation to Solution Focused Interactions; firstly, it clearly demonstrates that "you don't have to understand the patient's problem in order to help them find a solution to it", in fact, you don't even have to know what the problem is. As a nurse, this is so important: sometimes the patient can be too embarrassed to reveal what their problem actually is, sometimes the problem can be so painful that they are afraid to

even speak about it, sometimes the patient may not even know what the problem is themselves; but in each case they will know what a solution looks like (even if they don't know they know it). Secondly, it shows us that we can use simple, abstract scales to measure progress in someone's wellbeing. In a way, this shouldn't be surprising; we are all familiar with the use of pain scales, and the Glasgow Coma Scale is widely used across the world, mental health practice relies a great deal on any number of scales (the Becks Depression Inventory, the Hospital Anxiety and Depression Scale, the General Health Questionnaire etc.). However, all of these scales differ from Erickson's scale in two important ways; first of all they scale the problem (they measure the 'intensity' of the pain or the depression) whereas Erickson was scaling the 'solution' (when you don't need to see me again), and secondly, they are all based on the result of a number of questions in order to provide a total (or a mean) score, whereas Erickson's scale is based on one simple question. Zero is where you "don't want to be" and ten is "where you want to be": how close are you to ten? It's deceptively simple but amazingly adaptive; I can think of few things that can't be measured on some version of such a scale. We'll look at scaling in more detail later, but for the moment think of it as similar to the game we used to play when we were children. I think it was called "Blind Man's Buff"; one child was blindfolded and then had to find an object hidden somewhere in the play area. As they moved towards the object everyone else would shout "You're getting warmer", and as they moved away from the object the other children would shout, "You're getting colder". It usually didn't take too long for the child in the blindfold to figure out that if they followed the directions for "getting warmer" they would be able to home in on the prize. In the same way, Erickson's scale encourages us to do more of what takes us in the direction of "ten" and, conversely, to do less of what takes us in the direction of "zero".

John Weakland

I've included John Weakland here as representative of the group of family-therapists, including Don Jackson, Jay Haley, Paul Watzlawick and Richard Fisch, who developed the Brief Therapy Centre of the Mental Research Institute (MRI) at Palo Alto, California. This group were influenced by Erickson's work and sought to develop a therapeutic approach that was both "strategic" and "brief". By "strategic" I mean an approach whereby the therapist doesn't just allow a solution to emerge from the interaction with the patient (in broad terms you could say that this position was typical of the analytic/post-Freudian and counselling approaches used in the 1960's and '70's), but rather set out to create the circumstances in