The core dimension of Solution Focused Brief Therapy (SFBT) is a simple truth; the future is now (Frederick, 2008). The aim of this essay is to conduct an overview of SFBT with supporting evidence regarding the efficacy within the mental health acute inpatient setting. Its examines and explains the theory of SFBT giving a background and establishing its place in the acute environment. It explains its relevance in everyday practice and evaluates its performance in this setting, considering its advantages and disadvantages both in the clinical setting and my own practice. Finally it examines SFBT in contrast to two similar therapies Cognitive Behavioral Therapy (CBT) and the work of Alfred Adler. SFBT in the acute mental health setting is a relativity new concept. It is a frame work that was developed by De Shazer in Milwaukee, USA for the Brief Family Therapy Center. (De Shazer, 1985,1988, 1991). As a therapeutic approach SFBT offers the client a more general way of thinking and working with their problems. The therapy is structured around identifying client’s resources, strengths and their outlook of a future in which their problems are solved or not currently present. There are two key steps which the therapist needs to approach during the initial meeting with the client. First is to “establish where the client wants to get to” and second to “identify what the client has already done which is likely to help them get there”. This is where the Miracle Question synonymous with SFBT comes in to play (Ferraz & Wellman, 2008).

The Miracle question is one of many items in the SFBT tool kit. It is used to aid the client to envision ones own future without the problem being present. The question is often structured like;

“Suppose that when we finish this conversation and you leave the room at the end of today's activity you go to sleep. While you are asleep a miracle happens, and the miracle is that the problem which brought you here is solved. However, because this happened while you were asleep you don't know how the miracle happened. So when you wake up in the morning what will be the first things you notice that tell you that this miracle has happened?” (De Shazer, 1988)

The purpose of this question is to assist the client to visualise and give a description of how they would like things to be when this problem has been rectified. In addition to this...
it gives the individual permission to explore and think over an infinite range of outcomes and lets them see it is possible to move beyond their current problems (Dejong & Berg, 2002). It may however, given the circumstances, be prudent to ask a question that is more appropriate to the client. This may be an ideal or preferred future or a magic pill instead of a miracle happening (Ferraz & Wellman, 2008).

The clinician must then talk with the client to establish when the problem has been less of an intrusion into their life. These moments are referred to has “Exceptions”. The client is encouraged to elaborate on what was different at that time in their life compared to when the problem was heightened. It is ideal that the client will learn from this and be able to repeat what has worked or happened in the past to gain confidence and be more aware for exploring future situations (De Shazer, 1988).

“Scaling” is another technique that is commonly used in the SFBT tool kit. It allows clients to measure how close they are to their personal goals and desired outcomes. Clients are usually asked to rate their particular issue on a scale of 0 to 10, with 0 being the lowest of lows and 10 being that the problem no longer exists or does not impinge on their daily life. If for instance the clients rates their current state at a 3, the clinician can ask questions such as, “How come you are at a 3 and not a 2 or 1? What are you doing now to get you to a 3?” (Ferraz & Wellman, 2008). Using this the clinician may highlight the positives things currently happening in their life. The clinician then explores what it would take to step up to a 4. If the client can answer with ease then the clinician can ask for a description of these small difference and steps the individual has taken. It is however, that the focus of the conversation be about client focused solvable problems. It is important to formulate achievable goals with the client (Ferraz & Wellman, 2008).

Throughout many parts of the world there has been a significant trend in the number of large psychiatric hospitals closing and a major increase in the number of community based services (McDaid & Thornicroft, 2004). This decrease in the number of acute mental health facilities is increasingly more acute and using these services for a shorter amount of time due to bed constraints. A Swedish study revealed that these same clients were spending a significant time in the acute environment alone, with only 20% of their time during the day spent with nursing staff (Kristiansen, Dahl, Asplund & Hellzn, 2005).

During a short stay in a acute setting the individual may be cared for by many nurses and have many different interactions. The concept of introducing SFBT into the mental health nurses toolbox is to allow the nurses to engage the client in a therapeutic context within this small window of opportunity. SFBT offers a positive psycho-education role for the nurse whilst maintaining with view that the client has the ability to know what is best for themselves and can be assisted to plan effectively in how to achieve this.

A significant part of early studies into the effectiveness of SFBT where done by the originating Milwaukee team. The results where quite marked with upto 81% of participants claimed it made a significant improvement in their life (De Shazer, 1991). However an external review of available research was conducted by Gingerich & Eiseegart (2000). This review examined varying sources of literature and identified five well controlled studies into SFBT. Within these five studies all authors reported a positive outcome for the clients but not to the extent of the earlier Milwaukee research. Gingerich & Eiseegart (2000) concluded that the current level of research into SFBT is inconclusive to truly establish the efficacy of SFBT.

The literature reviewed by Gingerich & Eiseegart (2000) focus's on SFBT as a complete therapy. For the nurse this may be impractical. Significant research has been conducted in Colorado, USA. Webster (1990) highlights some key principles of nursing within the inpatient setting which also shares values with SFBT. ‘Focusing on expectations’ where clients shift their thinking to what is working for them know not repeated analysing their problems and ‘future orientation’ where the majority of the time is spent focusing on highlighting and moving towards goals (Webster, Vaughn & Martinez, 1994).
But how does any of this translate to being effective within the inpatient environment? There are two main studies that used the data provided by the Colorado reorganization that saw the introduction of SFBT into the nurse’s toolkit. Both Baker and Geise (1992) and Thomas, Rosenberg, Giese, Fryer, Dubovsky & Shore (1996) recorded a drop in the mean length of stay, a reduction of four weeks down to one. They do not however take into account the amount of clients whom may have increased their presentations and readmissions, nor does it take into account the aforementioned reduction in the amount of acute psychiatric beds. Whilst these are significant results more studies in a greater number of sites would need to be introduced to allow more pertinent results.

Bowles, Mackintosh & Torn (2001) conducted a similar study in the UK. It contained both quantitative and qualitative aspects over a six month period. Due to limitations Bowles et al (2001) did not make any generalisations about the patient population due to the small sample of clients. They did however report a positive change in the nurses involved in the study. They reported a ‘change in practice’ and a ‘rejection of problem orientated disclosure’. They conclude that SFBT techniques may be of relevance to mental health nursing (Bowles et al, 2001).

There is a significant collection of literature that supports SFBT in varying types of practice. Gutterman & Leite (2006) found that SFBT to be an effective model when used to assist clients with religious and spiritual issues. Macdonald (2005) investigated fifteen years of SFBT practice. They found that good outcomes were reported between 70-76% with most clients having 4 to 5 sessions. Macdonald indicates SFBT to be an effective treatment with the context of family therapy. Bowles et al (2001) established quantitative data that indicated a positive change in nurses practice following SFBT training. They state SFBT is a cost effective approach to training nurses in communication skills and provides a therapy that complainants the values inherit in nursing. Winship (2007) conducted an RCT which had a 80% positive outcome for clients with deliberate self harm issues. Finally Hosany, Wellman & Lowe (2007) found that training nurses in SFBT, even with a short 2 day course, was found to have a positive outcome within the clinical environment.

There is a significant collection of research being done with SFBT. Most studies have reported quite significant results in both its use in nursing and in family practice. Finding any evidence about contraindications or negative aspects has proven difficult with the above findings. Most of the studies do highlight a need for more studies with more tightly controlled criterion.

How is SFBT applicable to my practice? The Tamarind ward is a 25 bed unit comprised of varying levels of acuity and diagnosis. It is however quite frequent to get clients admitted due to current social stressors which may be exacerbating their current mental state. The generalised treatment plan for clients is of the medical model. Interview, adjust medications and monitor outcomes. SFBT offers the nurse and the client the facility to engage in proactive discussion about what led them here and where it is they feel they are going within a short time frame. There is currently no formal discharge planning service provided for mental health clients. SFBT may also aid in that process by outlining future plans.

For my practice this offers a dynamic process for aiding the therapeutic process and relationships. A significant percentage of our population turns over within a short period of time. Often by the time you have established a therapeutic relationship the client is being discharged. It is this short time frame that is the premise for researching SFBT and implementing it into my practice. Within my practice SFBT has allowed me to spend a session with a client that has led to them having established outcomes which are appropriate for that particular phase of their illness. I have found SFBT to an effective therapy to conduct in an acute environment that has limited time constraints.

Alfred Adler's work has contributed significantly in the modern shift towards constructive counseling (Watts & Pietrzak, 2000). It is however surrounded with some controversy when discussed in the context of SFBT. Watts highlights there is a significant amount of similarities between the theories contained in Alders work and SFBT. Watts & Pietrzak (2000) states that there exists similar constructionist approaches to SFBT with out any acknowledgment of Alders
work. In a similar context to SFBT Alder considers encouragement to be crucial within a human's development. Both Alder and SFBT do not adhere to the medical model and take similar non pathological approaches choosing to not view their clients as sick or being labeled by their diagnosis (Watts & Pietrzak, 2000). Both operate the counselor-client relationship as one of co operation, mutual, optimistic and collaborative. Both aim to facilitate change in the clients life by changing behaviors and attitudes form a problem focus to a solution focus and encourage self discovery in this process. Watts highlights that throughout these comparisons the authors concerned with SFBT do not acknowledge Allder's work even though it is apparent that they draw direct parallels (Watts & Pietrzak, 2000).

Cognitive Behavioral Therapy (CBT) is one of the most widely used forms of therapy today. Does SFBT offer anything over CBT? SFBT offers a fast approach to therapeutic change where as CBT can take considerably longer (Rothwell, 2005). Rothwell (2005) states that the mean length of the session for a client whom is partaking in SFBT is 2 where as compared to CBT which is 5. A therapist rated outcome scale showed similarities in rating the two groups (Rothwell, 2005). Whilst Rothwell's (2005) research indicates that SFBT is as effective as CBT. It is not without its limitations. Much of the SFBT group was smaller (n=41) as opposed to the CBT group (n=119). The SFBT group was conducted by a single therapist where the CBT group had multiple. One factor that is not looked into is the quality of the therapy itself. CBT offers the client a new way of thinking in respect to their emotions and thoughts. SFBT also offers a different way of viewing a situation and finding appropriate answers. During the course of researching this topic it was difficult to find any literature that draw similar parallels in terms of the long term qualities of CBT and SFBT.

The evidence provided would support the implementation of SFBT training and interventions by nursing staff in the acute inpatient environment. SFBT gives the individual conducting the therapy two key steps, the 'Miracle Question' and encouragement of the client to visualise and give a description of how would like things to be. The nurse can then use encouragement and scaling techniques to help solidify the clients perspectives. With many large psychiatric hospitals reducing beds and an increase in community services it is crucial that the short time spent with an acute client is efficient as possible. The current research is presenting figures of up to 70-80% improvement for clients in a shorter time frame then traditional therapeutic techniques such CBT. It has also shown a marked improvement in the mean length of stay. This research however is not with out its limitations and does require further RCT's with more quantitative client related data. Nurses involved in these studies have reported positive changes in their own practice and affirmative communication practice due to the SFBT training. Finally the evidence has shown that SFBT is a cost effective therapeutic intervention which can be conducted with a minimum of training.
References


