

CREATING
POSITIVE FUTURES

SOLUTION FOCUSED RECOVERY
FROM MENTAL DISTRESS

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CONTENTS

Foreword	ix
<i>Brian Cade</i>	
Introduction	1
<i>Rayya Ghul</i>	
1. A Solution Focus	11
<i>Rayya Ghul</i>	
2. The Solution Focused Measure of Occupational Function	43
<i>Lucie Duncan, Sarah Mousley, Rayya Ghul</i>	
3. Worksheets	87
<i>Sarah Mousley and Lucie Duncan</i>	
4. Continuing Professional Development	129
<i>Lucie Duncan and Sarah Mousley</i>	
5. Examples from Practice	155
<i>Lucie Duncan, Rayya Ghul, Sarah Mousley</i>	
References and Further Reading	203

INTRODUCTION

Rayya Ghul

In recent years, mental health service users have suggested that, as experts in their own experiences of being and living, they could perhaps be trusted to know what they want and need. Professionals working in mental health services could then be useful allies and collaborators in finding ways through the trickier aspects of living that clients experience. This is hard to do when mental distress is generally defined as a medical problem requiring a medical solution.

Mental illness, as conceived by medicine, is a problem requiring a solution. Those in mental distress are described as ‘people with mental health problems’, which suggests that in order to help them, all we need to do is solve a set of problems. This immediately poses the question: who defines the problems and determines what the ideal solutions might be? There is, of course, nothing wrong with problem-solving. However, the result is just that: a solution to a particular problem. For example, some doctors may see mental health problems in terms of chemical imbalances that require correction with medication. Some in society may see only ‘mad’ people who need to be locked up for the safety of others.

The solution focused approach liberates both service user and therapist from the constraints inherent in traditional approaches to problem-solving. Instead, it offers the possibility that each interaction between service user and therapist is an exploration of possible

2 · Creating Positive Futures

futures for someone trying to lead the best possible life. It is a radical approach to working in mental health and much more than a new method of problem-solving.

This book describes examples of working in a solution focused way within mental health services. Although it was written by occupational therapists it should be useful to any profession working with people in short or long-term mental distress. When we started writing this book in 2001, the idea of service user empowerment and involvement was in its infancy in mainstream British services. Now, a slow but insistent shift of power is taking place. Service users are becoming recognised as ‘experts in experience’ and there is a gradual dawning that effective services can only arise from collaboration and negotiation.

Central to this is the ‘recovery’ movement which provides a new narrative of living with shifting mental states and episodes of mental distress. Rather than viewing a person as lessened or limited through illness, the focus is on seeing that someone can continue to live, develop and flourish even when the illness is not ‘cured’. Anthony (1993, in Roberts & Wolfson, 2004) defines recovery as:

“a deeply personal, unique process of changing one’s attitudes, values, feelings, goals, skills and roles. It is a way of living a satisfying, hopeful, and contributing life even with limitations caused by the illness. Recovery involves the development of new meaning and purpose in one’s life as one grows beyond the catastrophic effects of mental illness.” (p39)

Throughout this book we hope you will see how the solution focused approach may well be the ideal one for responding to the recovery movement. It is fundamentally an approach of hopefulness. We see clients as resourceful and talented and holding the key to their own recovery. We believe that, given the opportunity, people respond to the challenge of setting their own priorities, pursuing their own interests and having the chance to grow beyond the limited expectations of traditional mental health practice. The ideas in this book demonstrate some of the ways

that this can be supported through careful listening and creating a positive focus through conversation. Using a solution focused approach has made it easy for us to feel optimistic about our clients and their chosen futures.

Occupational therapists have a great deal to offer mental health services. We are already accustomed to the idea that people can live fulfilled and productive lives despite chronic illness or disability, and we have a client-centred philosophy at the heart of our practice. Many of the examples in this book show how our understanding of everyday life informs the focus of our work. Increasingly, mental health services are being asked to look beyond diagnosis and symptoms and see the source of well-being as balance and competence in everyday activities. We therefore hope that it is not only the solution focused aspect of this book that will be useful to readers from different professions, but also the perspectives from occupational therapy.

Chapter One gives the reader an overview of solution focused brief therapy and provides transcripts of sessions to illustrate the types of conversation. At the end of the book there is a list of recommended books for readers who would like to learn more about the approach. Chapter Two introduces the Solution Focused Measure of Occupational Function and provides descriptions of how to use it with clients, as well as explanations and examples for each of the 25 questions. Chapter Three introduces a series of photocopiable worksheets that can be used on their own or in conjunction with the Measure. Chapter Four suggests ways that therapists can use the solution focused approach for their own continuing professional development. Lastly, Chapter Five contains transcribed case studies to illustrate how the Measure is used in practice, as well as how the information can be used to build a strengths-based report.

The authors' aim is that this book will provide a resource for all mental health professionals looking for ways to increase their effectiveness in client-centred practice. At the very least we hope that readers will try out the ideas and find them useful. At best we hope that the book contributes to ensuring that mental health service users are fully in control of their recovery.

4 · Creating Positive Futures

Solution Focused Occupational Therapy?

Despite having grown out of different traditions at different times, occupational therapy and solution focused brief therapy appear to share some important guiding principles. The British definition of client-centred occupational therapy is:

- A partnership between the client and the therapist that empowers the client to engage in functional performance and fulfil his or her occupational roles in a variety of environments.
 - The client participates actively in negotiating goals which are given priority and are at the centre of assessment.
 - Throughout the process the therapist listens to and respects the client's values, adapts the interventions to meet the client's needs and enables the client to make informed decisions.
- (Sumsion, 2000)*

The 'essence' of solution focused brief therapy is described by the Brief Therapy Practice as:

- To work with the person rather than the problem
 - To look for resources rather than deficits
 - To explore possible and preferred futures
 - To explore what is already contributing to those possible futures
 - To treat clients as the experts in all aspects of their lives
- (George, Iveson, Ratner, 1999)*

Keilhofner states of the core values of occupational therapy:

“Deeply ingrained in occupational therapy is a belief in each person's essential humanity and worth irrespective of any impairments. This commitment has supported occupational therapists in their involvement with the most disabled and difficult patients and clients. This value has also shaped the strong tendency in occupational therapy to focus on the assets of individuals and to emphasise them in the therapeutic process. Closely tied to this humanistic perspective is the conviction that it is important to know and respect the

unique perspective of the patient or client.” (*Kielhofner, 1992*)

It can be seen that the main areas of similarity between solution focused brief therapy and occupational therapy are those regarding the client as the expert in his or her own life, and the focus on strengths and resources rather than problems or disabilities. It is therefore not surprising that both approaches operate from a collaborative stance.

Occupational therapy and solution focused brief therapy also share a view of humans as unique individuals. People are believed to be unique in the way they think about themselves, how they do things, how they make sense of the world and how they change. This does not mean that these differences are always great. Like the rest of nature there are recognisable patterns such as different kinds of tree; no two trees are the same, but we still recognise them as trees. Similarly, there are different kinds of teenager and no two are the same but we can broadly recognise patterns of behaviour as being those of a teenager.

Taking into account each client’s unique perspective, both solution focused brief therapy and occupational therapy have become interested in the meanings clients ascribe to aspects of their life (for occupational therapists) and the way they talk about them (for solution focused brief therapists). Recent theorists in occupational therapy have stressed the importance of understanding occupation as meaningful and not simply as a set of activities or tasks.

For example, a client, John, with chronic pain syndrome and depression had become completely withdrawn from family life. He identified making a sandwich for his child’s lunchbox as a first step goal. The following week the client reported that he had made the sandwich and then decided to make the sandwiches on three days the next week. John was delighted with his progress and in particular the response of his daughter.

The simple activity of making a sandwich was a success for John, not in the simple terms of competence or skill but in the profound meaning the activity has for him; the return to a parental role within his family. The common sense or layperson’s view of occupation is that it is the activity life of a person; it is what they do. Occupation is viewed as a set

6 · Creating Positive Futures

of actions requiring different skill levels that can be learned and taught. While this is undoubtedly an important quality of occupation it does not take into account the human being who is carrying out the occupation. If we think again of the trees and teenagers, we see that people perform their occupations in a unique way.

A good occupational therapist knows that occupation is inherently purposeful and meaningful and they utilise this in therapy. John's therapist was willing to understand the meaning of sandwich-making for him (the client with chronic pain syndrome). She did not assume that he would be better off using his energy by going to the upstairs toilet. Conversely, an intervention, however well-reasoned, which is not meaningful for the client will not be effective. This is why many pieces of equipment lie unused in the homes of disabled people and why the in-patient in a mental health unit may not want to attend a pre-determined group programme. Occupation possesses 'a multidimensionality of an activity in context' (Gray, 1998, p358). It refers to activities that are 'perceived as "doing"; pertaining to the client's sense of self; goal-directed, personally meaningful, and culturally and developmentally relevant' (Christiansen, 1994, Clark et al, 1991, Gray, 1997 cited in Gray, 1998 p358). In other words it is the right activity, at the right time, in the right place. It is identified by the client as something that they need and value and is appropriate to their age and culture.

When this emphasis on meaning is taken into account, the way questions are framed and asked in solution focused brief therapy links closely into occupational therapy. The use of language as a therapeutic tool in interviews has not been extensively explored or written about in occupational therapy literature. However, there has been acknowledgement of this in writing on client-centred practice. Sumsion (1999, p32) states that 'The actions necessary to be truly client centred will not occur if the process does not begin with and continue to include the words that convey a commitment to this approach and the client's central role throughout the process.'

John's goal of making a sandwich was arrived at during a solution focused interview. He had been asked to talk about a time in his life when he felt things were going well. During this conversation he had

identified a time when he was able to contribute to the family financially and emotionally. He had described this time in some detail and with some emotion associated with loss of that lifestyle. The therapist then asked, 'What would be the first small sign that your life was beginning to become more like that again?'

These 'signs' that the client searches for and highlights in the process of a solution focused interview are the meanings unique to their life. They are the (often unconscious) markers that tell us we are doing well in our aspirations, that we are on the right track. For people who have suffered trauma or disruption of their mental health, regaining a focus on these important signs can be the key to recovery or taking control of their lives. For many of our client this may be the first time that anyone has asked them what they want. Rather than viewing the client as being in the dark and the role of the therapist to provide a torch to light the way, working collaboratively in a solution focused approach means the therapist and client are in the dark together but with two torches.

Occupational therapy and solution focused brief therapy are each in their own right important contributions to the world of mental health work. Integrating the skills and ideas of solution focused work should enhance collaboration with our clients since the approaches share an important ideological common ground. Solution focused conversations allow the client to carry out their own occupational analysis through describing in detail what they will be doing when life is going well. For clients who do not require direct assistance with developing occupations, the occupational therapist may find that through using solution focused questioning, they are encouraging clients to take control of their own progress and that their role is more of coach than therapist.

Sometimes, however, conversation is not enough. The understanding that occupational therapy has of 'occupation' is enormously important to our practice and allows us to engage with clients with complex needs. For example, the occupational therapist knows how to grade and adapt occupations. This ensures that the client experiences success and challenge in a useful balance. A client who wants to learn computing skills may not be ready to go to college because of a lack of self-confidence or social skills following an episode of unstable mental health. In solution

8 · Creating Positive Futures

focused brief therapy the client is encouraged to identify small signs of progress towards their preferred future. In some areas of life, acting on this is not always possible. For example, enrolment on a course generally requires regular attendance and participation. Being able to attend a graded programme in a resource house or day service provides a good stepping-stone for the client to achieve their goal.

We are suggesting that solution focused brief therapy provides a frame of reference for using conversation as a therapeutic tool within all parts of the occupational therapy process from assessment to discharge. It also provides from the outset a way of engaging and respecting the client's perspective in clinical reasoning. These ideas are aimed at integrating and enhancing practice rather than replacing it.

Sumsion, (1999, p32) states that 'the application of a client-centred practice requires the adoption of a new language. Few new words are required but the pattern of word usage must be changed.' The authors believe solution focused brief therapy will be a significant contribution to this enterprise.

Development of the Solution Focused Measure of Occupational Function

The ideas shared in this book are the result of the authors' experiences of finding ways to integrate a solution focused approach with occupational therapy without compromising either. In 1999 Lucie Duncan and Sarah Mousley began to develop an interview assessment tool based on solution focused principles. They did the majority of the work on what has now become the Solution Focused Measure of Occupational Function, which is introduced in this book.

The Measure was further developed in collaboration with Rayya Ghul. At the end of 1999 the first version was piloted for three months by 25 occupational therapists working in mental health settings in what was then South East Kent Community Trust. At the end of the pilot the participating therapists completed a questionnaire regarding the perceived usefulness of the Measure, and suggestions for improvement were sought. The result of the pilot suggested that the Measure was seen as highly useful, easy to use and fitting well with existing occupa-

tional therapy practice. Changes to the Measure were made based on the suggestions received. Following the pilot, the second version of the Measure was distributed to the participating occupational therapists and the decision was made at management level to approve the Measure for use within the Trust, where it is now in regular use.

From 2002-5, the Measure was used as an assessed task within the second-year mental health course at Canterbury Christ Church University College. Students completed the Measure from a tape recorded interview and provided a formulation of the occupational performance needs of the 'client' in the case study. The exercise was completed twice each year (once as a practice and once as an assessment) by three cohorts of approximately 70 students, providing evidence for the consistency of results. Despite variations in the quality of the information, as would be expected from undergraduates, the content of the reasoning and analysis remained remarkably consistent for a sample of around 420 scripts. During this time, further changes were made to the Measure and the third and final version, which appears in this book, was completed.

CHAPTER ONE

A SOLUTION FOCUS

Rayya Ghul

The solution focused approach has its origin in Solution Focused Brief Therapy which was developed by Steve de Shazer and Insoo Kim Berg and their colleagues at the Brief Therapy Center in Milwaukee, USA, in the early 1980s. Since then, there has been considerable interest in the approach by health and social care professionals working in every conceivable setting with a huge variety of client groups all over the world. It was introduced into Britain by Evan George, Chris Iveson and Harvey Ratner while they were working together in an NHS child, family and adult psychiatric clinic in central London. They then set up the Brief Therapy Practice, the first solution focused brief therapy centre in the UK and offered training in the approach. While the majority of this book deals with applying a solution focus to working in mental health services, it will be useful first to look at solution focused brief therapy and its main components.

Solution focused brief therapy is a ‘talking’ therapy in that it takes place in the form of a conversation between therapist and client (or clients). Readers will be aware of other therapies such as cognitive behaviour therapy or psychodynamic psychotherapy. The main observable difference between these therapies is in the way that the therapist talks to the client; specifically, language is their tool. It may be an obvious point to make, but it is worth considering. The way a question is framed or phrased has a specific power and result. For example, in

conversation with someone who has suffered abuse, asking ‘How did you respond to what was happening?’ will lead to a completely different conversation than ‘How did what was happening affect you?’ The reason is that the meaning of ‘respond’ indicates some sort of choice, power or locus of control, however limited. ‘Affect’ implies a passive experience where all the power is with the person or object that *affects* the person. These two conversations will be experienced differently by the client. Talking about responses is more likely to allow the client to discover signs of their strength and resources, rather than talking about effects which might reinforce the experience of being a victim.

The form of verbal communication used in various therapies reflects the focus of the therapy. For example, a cognitive behaviour therapist might ask, ‘Just before you lose your temper in a traffic jam, what thought pops into your mind?’ He or she is trying to elicit an automatic thought because they believe that by challenging these thoughts the client can change their behaviour. On the other hand, a psychodynamic psychotherapist might say, ‘It’s interesting that whenever you talk about your father, you use words that describe a battle.’ The therapist is trying to encourage the development of insight because they believe this will help the client make changes. In both these cases, the questions are ways to engage the client in a process of psychological change based on the theoretical belief system of the therapist.

Traditional therapies have for the most part arisen from developing an idea of the ‘healthy’ person and then seeing the problems people experience as deviating from this ideal. Therapy is then designed to ‘correct’ this deviance back to the norm. Solution focused brief therapy does not diagnose, formulate or prescribe. It is, at its simplest, a conversation between therapist and client which in itself may help to provide a different experience of a problem and therefore uncover possible solutions that were not, and possibly could not, be considered previously. It acknowledges and utilises the dynamic and systemic aspects of human experience. This is not to say the solution focused brief therapy is somehow better than a therapy based on a normative model, but to highlight this fundamental difference. However, we believe this difference makes solution focused brief therapy closer to the paradigm of

occupational therapy and therefore more congruent in practice.

In solution focused brief therapy there is no universal theory of human psychological function or therapeutic change. The therapist does not know which solutions will work with any given client. Instead there is an acknowledgement of difference between people. Everyone is unique in the way they think about themselves, how they do things, how they make sense of the world and how they change. Therefore the solution focused therapist doesn't believe they know *how* a given client will change or make changes as a result of their meeting. Instead they believe that talking about those desired changes in a specific way is more likely to help their clients' experience of life improve.

A good way of thinking about solution focused questions is to ask 'Will asking this question lead to a useful conversation?' Of course this begs the question: what does 'useful' mean? If we consider the 'essence' of solution focused brief therapy as suggested by the Brief Therapy Practice as:

- To work with the person rather than the problem
- To look for resources rather than deficits
- To explore possible and preferred futures
- To explore what is already contributing to these possible futures
- To treat clients as the experts in all aspects of their lives

(George, Iveson, Ratner, 1999)

A 'useful' conversation would be one that allows the above points to be achieved. As you consider the transcribed conversations in this book, it might be helpful to refer back to these points and consider how each question the therapist asks fits in with these statements.

The solution focused questions that lead to useful conversations fall into three broad categories:

- Preferred future questions
- Exception questions
- Scaling questions

In addition, to structure the interview the therapist will also make use of the following conversational aspects which are specific applications of the above questions. They conform to the definition of 'usefulness' in

14 · Creating Positive Futures

relation to the ‘essence of solution focused brief therapy’ as developed by the Brief Therapy Practice.

- Problem-free talk
- Pre-session change
- Coping questions
- Compliments/positive feedback

Goal-setting arises naturally out of the solution focus process, as will be seen.

Preferred Future

The solution focused brief therapist is interested in what their client wants from therapy and how this will change their life. All clients have some idea of how they would prefer their future to be, even if this is simply expressed as an absence of something such as unhappiness or discomfort. The questions the therapist may ask will encourage clients to think about this future in great detail, focusing on everyday experience rather than general goals. The answers have meaning for the client as a sign of life going well. While forming goals based on these answers can be useful, at this stage, identifying ‘markers’ of success is important. Clients often lose sight of these signs when they have suffered disruption of their life through mental and emotional distress. This contributes to the client’s sense of loss of self or having lost control or direction in life. Asking questions which require the client to identify these signs can be grounding and provides a sense of being back on track.

Examples of such questions:

- How will you know that coming to see me was worthwhile?
What difference will you see in yourself and your life?
- What will you see yourself doing differently when life is going well again?

The answers and conversations elicited by these questions will differ from client to client. The skill of the therapist lies in ensuring that the client has a clear picture of their preferred future which is expressed in concrete, positive terms. For example:

THERAPIST: What will you see yourself doing differently when

life is going well again?

CLIENT: I won't be staying at home doing nothing all day.

This answer is merely an absence of something undesired and tells the therapist and client nothing about what will be happening. The therapist will need to continue the conversation.

THERAPIST: What will you be doing instead?

CLIENT: I'll be seeing my friends more often.

THERAPIST: OK, how often do you think you'd be seeing them?

CLIENT: Well, I'd probably be seeing my close friend at least once a week and others less often.

THERAPIST: What would you be doing with your friends when you saw them?

CLIENT: With my close friend I usually go to her house or she comes round to mine and we drink tea and chat and put the world to rights!

THERAPIST: What sort of things do you talk about?

CLIENT: Oh you know, the trouble with men, the price of cigarettes (*laughs*).

THERAPIST: What is it about being with your friend that you value?

CLIENT: She makes me feel normal and that I'm as good as other people.

THERAPIST: How do you usually arrange to see your friend?

CLIENT: Oh we used to text each other regularly and sort of had a regular arrangement to meet.

THERAPIST: What about your other friends?

And so on.

At the end of this conversation the therapist will look for signs that some of this may be happening already.

THERAPIST: Are there any signs that some of what you've described is happening at the moment?

CLIENT: Well, my friend did text me the other day wondering how I was.

THERAPIST: How did you respond?

CLIENT: I didn't really know what to say so I left it, I but I

16 · Creating Positive Futures

did feel pleased that she'd thought of me.

The therapist may then encourage the client to identify signs of what would be happening when life was getting better.

THERAPIST: So, what small sign would let you know that things were getting better?

CLIENT: I might reply to my friend when she texts me or maybe I'll send her a text.

THERAPIST: What difference would that make?

CLIENT: I'd feel like I wasn't all alone and that I was beginning to come out of this depression.

Asking what difference an identified activity would make is a very useful question. It helps clients to remember what is important to them. When people have suffered any sort of mental instability, they can often feel very vulnerable and unsure. Friends, family and health professionals may have given them advice about what to do, which can lead to clients feeling even more incompetent and unsure. There is a sense that asking the above questions is about getting the clients to uncover their own evidence on which they will then base their actions. Sometimes when a therapist asks about a possible difference, the client will say that there would be no difference. This is useful! The client need not then waste their energy and can concentrate on identifying something that *will* make a difference.

These small signs are often things that a therapist would not be able to uncover through formal assessment. Often they are things which could appear trivial and easily overlooked. For example, one client identified being able to complete the crossword of a certain newspaper as a sign of being well. She then used 'being able to do a little bit more of the crossword each week' as a sign of progress. The way this sign was discussed also meant that the client noticed and valued every extra word she was able to get each week, rather than focusing on *still* not being able to complete the crossword.

Another way of starting a conversation about the client's preferred future is to ask what is known as the 'miracle question'.

- Imagine you go to sleep tonight and while you are sleeping, a miracle happens and the problems that brought you here

today are no longer significant in your life. Because you were sleeping you don't know this miracle happened... so when you wake up, what is the first thing you notice that tells you the miracle has happened?

This question is a powerful way of beginning a conversation about a preferred future. The client is asked to bypass all the problems they are experiencing hence their answer is less constrained by their current experience. It gives the client permission to dream a little. It is important when asking this question to remember this aspect and not be concerned if some answers are unrealistic. We all long for things that are impossible such as being able to lose all that extra weight overnight without having to change our diet or take up exercise. What is useful about answers to this and similar questions is how the client thinks having their answer come true will change their life.

For example, 30 clients might all say in response to this question, 'I would have won the lottery.' The therapist would then ask, 'What difference would this make?' There would probably be 30 different answers all signifying the unique meaning that winning the lottery would make to each client. When we long for things it is usually because it signifies the attainment of something different; there is often a deeper meaning hidden from ourselves. If the therapist does not search for this, they will miss important information. Exploring an unattainable desire often leads to possible actions or solutions that were previously unseen because the focus was solely on the desire.

For example, a playgroup invited one of the authors to run a team building workshop since staff morale was low because they had lost a bid for a new building which they thought would solve their problems. The staff were asked to imagine the 'miracle' playgroup; what it would look like, what would be happening, what they would be doing differently. The staff filled five flipchart pages with ideas. Looking at these they found that of all the identified changes, only one was dependent on a change of venue. They had effectively paralysed themselves by being fixated on something that *symbolised* all the changes they wanted rather than looking at the changes themselves. Clients often become paralysed in the same way, for example when a partner leaves and they see their

recovery dependent on getting back with the partner.

Asking the miracle question can therefore lead to a freeing-up of possible solutions by focusing on the minutiae of change. The therapist ensures that the meaning of the desired change is clarified and also that it is, as previously mentioned, expressed in concrete positive terms. When beginning to use the miracle question it is a good idea to contain it through a 'miracle day' from morning to night, eliciting as much detail as possible about each stage. Many solution focused brief therapists always ask the question in this way, while others adapt it to specific situations or timescales. As discussed in the introduction, using the miracle question to gain a detailed picture of daily life in the client's preferred future is a way of getting the client to carry out their own occupational analysis.

Case 1 Janet

Janet, a young woman of 22, was an in-patient having suffered an acute depressive episode following the break-up of her first serious relationship.

THERAPIST: Imagine you go to sleep tonight and while you are sleeping, a miracle happens and life becomes the way you would like it to be. Because you were sleeping you don't know this miracle happened... so when you wake up, what is the first thing you notice that tells you the miracle has happened?

JANET: I wouldn't be feeling sad and depressed all the time.

THERAPIST: What would you be feeling instead?

JANET: I don't know, I suppose I'd be feeling happy.

THERAPIST: How would you know you were feeling happy?

JANET: I wouldn't have this heavy feeling in my stomach.

THERAPIST: So how would your stomach feel?

JANET: *(long pause)*... You know, I think I'd be feeling hungry!

THERAPIST: So what would be the first thing you'd do on this miracle morning?

JANET: Well, I'd get out of bed and make myself some

breakfast.

THERAPIST: What difference would that make?

JANET: It would be different because I have to drag myself out of bed at the moment and don't feel like eating and usually just have some black coffee and a cigarette.

THERAPIST: So what would it be like instead?

JANET: Well, I'd get out of bed sort of looking forward to the day and shower and have a proper breakfast.

THERAPIST: What would you be looking forward to doing?

JANET: Hmm, maybe going to work or doing something nice if it was the weekend.

THERAPIST: Tell me a little bit about how that day would go. How would you know things were different?

JANET: Well, like I said I'd have a proper breakfast. You know at weekends I always used to like a cooked breakfast on a Saturday morning at the local café. I bet they're wondering where I am.

THERAPIST: How else would you know things were different?

JANET: To be honest I'd probably take a little more care of myself.

THERAPIST: Tell me a bit about what you mean by that?

JANET: You know, make sure my clothes were clean and that I'd washed and done my hair. I never used to let my hair get like this. I'd probably put on some make-up.

THERAPIST: What difference would that make?

JANET: I'd feel a lot better about myself, like I mattered.

THERAPIST: So what else would you do if you felt like you mattered?

JANET: I'd go back to college. I was learning hairdressing before I got ill. I've always wanted to be a hairdresser.

THERAPIST: How did you do that – hairdressing?

JANET: Well, you have to learn about how to cut hair,

20 · Creating Positive Futures

what products to use, all about how to mix dyes and apply them. I really liked doing braiding and French plaits you know.

THERAPIST: Wow, how did you do that?

JANET: You have to be good with your fingers – you know careful, patient and be good at dividing the hair.

Janet went on to identify other things she would be doing when life was going well. At the end of the conversation the therapist asked:

THERAPIST: So can you see any signs of the miracle happening at the moment?

JANET: You know it's funny but you know Sally on the ward? She knows I was doing hairdressing and she asked if I'd braid her hair – you know she's got that beautiful long hair? I didn't want to do it – I thought I'd probably mess it up – but it did make me feel good that she'd asked me and I'd love to have a go on her hair.

THERAPIST: What else is happening that is a sign that the miracle is beginning to happen?

JANET: Well, yesterday at the social group I realised that I'd enjoyed myself talking to people and hadn't thought about John until I got back to the ward, so maybe I'm beginning to get over all that.

THERAPIST: That's amazing, so how do you think you did that?

JANET: Well, I suppose I was distracted because I was talking to people

THERAPIST: So how did that work?

JANET: I'm not sure, maybe I am getting better at concentrating.

Occupational therapists do not view their clients in isolation. They view humans in a holistic way and consider the wider system of their clients in assessment and intervention. In order to gain a clear picture of their capacity in activities of daily living they consider the relationship between the person, the occupation they are engaging in and the environment in which the occupation is taking place (*Strong et al, 1999*).

It is this way of thinking that makes it possible for an occupational therapist to see beyond a person's impairments and to adapt occupations or environments to enable occupation. Feelings, thoughts and actions arise from a complex dynamic interplay between internal components and external influences, which could be any kind of input from the colour of a wall to the way someone speaks to them (*Kielhofner, 2002*). This explains, for example, why clients may perform a task differently at home than in the hospital. It also allows the possibility that changing aspects of the environment, even in a very small way can change behaviour or feelings.

This systemic perspective also occurs within solution focused brief therapy. Building on a conversation about a preferred future, the therapist can include a variety of questions relating to the client's environment and relationships which can help to provide even more meaning or unique markers of a successful outcome.

Questions you could ask would be:

- When the miracle happens what would your spouse (or significant other, family members, close friends etc.) notice that was different?
- What difference would that make?

Case 2 Katherine

Katherine, a youthful 56 year old woman, was referred to the occupational therapist in the community. She had been working for many years as an administrator in a local factory and had the reputation of being extremely hard-working and energetic. She was married and had two adult sons. She was being treated for anxiety and depression following a traumatic incident where her son was falsely accused of a serious offence and was taken from home by armed police. He was subsequently acquitted. After a spell off work she was finding it hard to return because of recurring panic attacks. During the interview Katherine had identified her preferred future as not being at work but being at home reading and gardening. She did not see this as a realistic future but as a 'miracle'.

THERAPIST: So what would your husband notice that was

22 · Creating Positive Futures

different when your miracle has happened?

KATHERINE: Well, he'd notice that I was a lot calmer and quieter.

THERAPIST: What difference would that make?

KATHERINE: Actually I think he'd find it rather weird. I'm such an active person always running around doing things for people, seeing friends and so on. I've always done everything at home, made all the decisions, been very concerned about doing everything just so. Since I've been ill I've been doing none of that. I'm not going out and I don't want to see people except my closest friends. That's one of the reasons that he's so worried about me at the moment because I'm not myself.

THERAPIST: So if you got your miracle, your husband would think you were still ill?

KATHERINE: Yes I think so.

THERAPIST: So what would need to be different for you to get your miracle but also not worry your husband.

KATHERINE: I don't know. I've changed so much since [the incident] that I don't think I'll ever be that active person again. I felt so angry that such a thing could happen, I've always tried to be a good person and do things for other people but I feel so tired now. I feel I want to be totally selfish.

THERAPIST: What difference would being selfish make?

KATHERINE: I don't know but I think I deserve to have what I want now and somehow having been forced to stop rushing around has given me time to think and I really enjoy the peacefulness of being at home just doing what I want when I want it. But it's wrong to be selfish isn't it?

THERAPIST: What would your sons say about what you're telling me?

KATHERINE: (*laughs*) They'd say it was about time! They've always said I do too much and should be more

selfish.

THERAPIST: OK, so let me ask you again what would need to be different for your husband to accept the new Katherine?

KATHERINE: Well, maybe I need to talk to him more about it, like I've been talking to you. I think he's worried that I'll withdraw from him completely or maybe even leave him, but I still love him just like always. Maybe he needs to know that.

THERAPIST: So how will you know that your husband is OK about some of the changes you'd like to make?

KATHERINE: Well, he'd understand that he'd have to ask me before accepting invitations because I don't want to go out all the time. Really there are only a few people I want to socialise with regularly. Also I think we'd do more things together, just him and me. Simple things like going for a drive and a pub lunch.

THERAPIST: Is talking to your husband about these things a possibility?

KATHERINE: Yes, definitely. He'll find it strange, but I'm sure we could.

Bringing in the systemic view to this conversation allowed Katherine to identify her dilemma. Getting better would mean returning to a life she didn't want any more, but doing more of what she'd discovered she enjoyed could be interpreted by her husband and others as remaining ill. Katherine did talk to her husband, and as she had predicted he did find it strange at first and was very concerned. However, after six months she had left work and started up a flower arranging business which she could do from home. Her relationship with her husband improved as he became used to the new Katherine, and as she grew in confidence, he stopped being concerned.

About the Authors

Lucie Duncan is currently working as a Head Occupational Therapist and Group Coordinator in South Kent. She qualified as an Occupational Therapist from St. Andrews Hospital, Northampton (Leicester University) in 1995. Since qualifying she has specialised in mental health work. She has worked in a variety of settings including a community older adult team and an acute adult in-patient unit. Her main practice area has been community adult mental health.

Since discovering solution focused practice her work as an occupational therapist has evolved and developed considerably. She has been able to enhance her occupational therapy skills and work more collaboratively and successfully with service users.

Rayya Ghul is senior lecturer in occupational therapy at Canterbury Christ Church University, where she has worked since 2000. She qualified from the London School of Occupational Therapy in 1982. She has worked in a variety of mental health settings in London, Reading and more recently, East Kent. She also worked for some time promoting arts for disabled people with Shape London.

In 1997 she attended a solution focused brief training course at the Brief Therapy Practice and began to apply a solution focus to her work in mental health services with exciting and sometimes surprising results. Since then she has been interested in developing ways of integrating a solution focus into occupational therapy and other health and social care professions and processes.

Rayya has been involved in training for some years and provided courses in solution focused brief therapy for East Kent NHS Trusts. She has taught solution focused brief therapy at the University of Kent at Canterbury and the Institute of Psychiatry in London. She has consulted

with teams to develop solution focused practice in a range of health and social care settings, both physical and mental health. She has presented on integrating a solution focused approach at national and international conferences.

Sarah Mousley has worked as an occupational therapist for 10 years. She qualified in 1992 from Dorset House of Occupational Therapy, Oxford.

She has specialised in the field of mental health, working in a variety of settings including community mental health teams, residential and rehabilitation services and a day hospital. At time of publication she has been taking a break from her career to bring up her children.

On discovering solution focused therapy, she found that looking at clients' strengths and resources seemed to fit naturally with the vision of occupational therapy. She has been incorporating these ideas into her work ever since, finding the process creative and inspiring.

We hope that you have found the ideas in this book useful and inspiring. When we talk together about the difference a solution focus has made to our work as occupational therapists in mental health services, the most important aspect for all of us has been the shift from seeing our clients as walking problems, diagnoses or even as potential risks, to seeing them as people with strengths and resources, hopes and dreams, and possibilities for a positive future.

“A pile of rocks ceases to be a rock pile when somebody contemplates it with the idea of a cathedral.”

Antoine de Saint-Exupery



Lucie Duncan



Rayya Ghul



Sarah Mousley

This book has been written over many cups of tea! Many biscuits and cakes have been consumed but our favourite, and the one that has provided us with the most brain power is the following:

Flapjacks

Heat 6oz butter/margarine with 1oz syrup in a saucepan until melted. Add 4oz soft brown sugar, 8oz porridge oats, 2oz desiccated coconut and 1 teaspoon ground ginger. Stir until all ingredients are combined. Put into a greased tin (approx 12" x 7")

Cook for 15 minutes at 180°C

Cut into squares whilst warm

Leave in tin to cool

Best enjoyed without a book to write