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PREFACE

Solution Focused Brief Therapy as a new approach in psychotherapy came into existence during 1980's. Since its emergence as a therapeutic approach, it has been widely practiced in a broad range of settings in North America, Europe, and Asia. SFBT gained attention and acceptance among social workers, psychologists and other human service professionals because of its focus on strengths and solutions rather than deficits and problems. Popularity of SFBT was attributed to its applicability at lower costs of time and money when compared to traditional methods of psychotherapy.

In spite of its wide application across the globe, only a very few publications and discussions on Solution Focused approach were done in India indicating that not many Indian practitioners have taken it up as an earnest practice. This is in contrast with the wide scope of solution-focused practices in Indian behavioral and social science fields. With less accessibility and availability of psychotherapy in general, and in most cases urban areas being the only places for availing psychotherapy services, solution focused therapeutic approach may be an answer for India to reach more people in less time. The advantage of Solution focused approach lie in its already established application in varied fields such as education, social work, health profession, family settings and organizations.

Solution focused approaches are known for its flexibility in its practice and for its use across various cultures and settings and not being a therapy with a rigid framework. Making these advantages as the background and with an objective of spreading and popularizing its application in India, Association of Solution Focused Practices- India (ASFP-I) was founded in 2011. Since its inception, ASFP-I was active in facilitating trainings, workshops and research in the field of Solution Focused Approaches. With an aim of expanding its activities and to build a platform for Indian practitioners, researchers and students, ASFP-I decided to conduct an international conference. Recognizing the genuine interest of association in popularizing the approach, Human Care Foundation and CDMRP-

Calicut University came forward with all their support as joint organizers. Thus took the birth of the international Conference on Solution focused practices in behavioral sciences; a first international event on solution- focused practices in India, supported by European Brief Therapy Association (EBTA). Along with the conference, it was also decided to conduct the annual meet of Association for Solution Focused Practices- India.

Being the first training event in India in solution focused practices, the delegates of the conference were exposed to the basic concepts of solution-focused approach, solution focused techniques and its application in different areas including community interventions. The conference events spanning from 22nd December 2016 to 24th December 2016 included keynotes, workshops, and paper presentations by both national and international delegates whose expertise ranging across Psychology, Social Work, Mental Health practice, Special Education, Psychiatry, Community Service, leadership and various other fields. Through out the conference, focus was also given on exploring the current research and evidences of solution-focused practices around the globe. The conference proceeding has included selected chapters and papers presented at the conference. In addition, some relevant research papers on Solution focused approaches were also included.

Jaseem Kooranot
Organizing secretary
ICSFP2016

CHAPTER I

WAYS OF KNOWING: EXTENDING THE POSSIBILITIES FOR SOLUTION FOCUSED PRACTICE

John Wheeler

Introduction

Two particular experiences this year stimulated a growing curiosity about what might be thought of as ways of knowing, and the implications of this for my solution-focused practice.

The first experience happened during the EBTA summer camp on Inkoo Island in Finland in July. The group was out doors and standing in a circle. Ursula Buehlmann passed round the circle two packs of picture cards (Zürcher Ressourcenmodell) and asked each of us to choose a card that represented a good outcome for something we were currently planning. We were then invited to look at the picture and just let our thoughts happen. Specifically, we were told not to talk about what we were thinking. The more I looked at the picture, without talking, the more my thoughts developed. The second experience happened in a workshop on circle dance and poetry at the EBTA conference in Bruges in September. When we had finished circle dancing we were instructed to use the structure of a pantoum to write a poem. In particular, we were instructed to just let our hands do the writing. My hand took me by surprise when I saw what it had written.

In the preface to More than Miracles, the group that came together to discuss their solution-focused practice, and ultimately write the book, are referred to as "seasoned therapists" (2007, p. xii). Whilst it will be for my clients and colleagues to decide whether I can count myself as a seasoned therapist, I do know that my solution-focused practice has been seasoned in many ways since I was first introduced to the approach in 1991 – feedback from clients, watching many videos of the therapists from whom I have taken inspiration, reading and, as noted above, workshops at conferences and elsewhere.

In this paper I will present some recent thoughts on possible differences between Steve deShazer and Insoo Kim Berg, with regards to ways of knowing, share three case examples where other ways of knowing appear to have been helpful to the client, consider

how these different ways of knowing might connect to new sources of inspiration from the world of philosophy and conclude with questions about how we might stay solution-focused when other ways of knowing have come into the work.

How SFBT came about

There are many accounts we can now read on how SFBT came about. Eve Lipchik, for example, recalled that the approach was,

"…the end result of the efforts of a group of people who sat around at the Brief Family Therapy Centre in Milwaukee … and energised each other with their enthusiasm for new ideas about how people change." (2002, p. xiii)

A vivid account, I would suggest of people seasoning each other. Thanks to the work of this group, and those who introduced me to their ideas, my work since 1991 has usually included,

- Positive goals for change to help people work out where they want to be
- Exceptions to help people recognise times when they experience some of the life they want
- Scaling questions to help people notice how far they are on their journey to where they want to be and small signs of progress.
- The Miracle Question to help people work out where they want to be and small signs of progress
- Positive feedback to help people recognise how some degree of success has already happened.

Steve deShazer and Insoo Kim Berg – similarities and differences

Most of the videos from the work of BFTC are of the work of Steve deShazer and Insoo Kim Berg and watching these videos is likely to have seasoned my practice in many significant ways. As time has gone by I have noticed that, whilst I am substantially influenced by what they had in common, I may also have been influenced by some differences.

Steve de Shazer attributed a great deal of his seasoning as a therapist to Insoo Kim Berg, often saying that he learnt everything he knew about SFBT by watching Insoo. In the preface to "Patterns of Brief Therapy" (1982), for example he says,

"I just put them down on paper" (pp ix-x.)

When you look at the practice of Steve and Insoo, you can see that both saw their clients as being the experts on where they wanted to get to and how to get there. Both frequently used the solution-focused tools that had been found to be useful. Given that Steve learnt all he knew about SFBT from watching Insoo, does this mean that he was a replica of Insoo? Well, no. For me that's one of the interesting consequences of people seasoning each other. The flavouring may be detectable but the overall taste will be unique.

When I've looked at videos of their practice I've noticed that Steve almost entirely stuck to conversation as a way of helping people to make the changes they wanted to make. On occasions Steve might use his hands, or draw a scale on a piece of paper to help people answer the question, but from what I have seen this was rare, and it's as far as he went in doing something different from talking. I wonder whether this was partly due to where Steve looked for inspiration from the world of philosophy – Wittgenstein, who principle interest was in language.

An interview by Arnoud Huibers with Steve deShazer in (2005) shows Steve's understanding of the importance to him of both Insoo and Wittgenstein.

AH: SFT is often connected with Wittgensteinian philosophy. Could you explain the link?
SdeS: As I see it, my job is to make useful descriptions of what Insoo and her clients do that works. Once I have those, then I can try them with my clients, then into research, and training etc. Sometimes I need help with this, particularly when trying to make these descriptions make sense to other people and often Wittgenstein helps.

In Insoo's interview with a 5 ½ year old boy in the video for "Interviewing for Solutions" (De Jong, P. & Berg, I.,K. 2002) we see Insoo do something I've never seen Steve do. Insoo starts the interview with problem-free talk and compliments the boy on his abilities. Insoo then uses a scaling question with 10 meaning that an adult at school who has been helping the boy would say he has his temper problem under control. The boy says he is at 10. When asked how he has done this says he doesn't know. Insoo tries a variety of questions – what the boy's mother knows about how has done this, what it's like not having a temper problem, what he does now. In response he either says "good" or shrugs his shoulders. Insoo then asks him to draw pictures of when temper was very bad and now that things are at 10. Through drawing two pictures the boy is able to describe how he is now being kind to people, counts from 10 backwards when he feels like punching something, is happy and his mother is buying him things.

I would like to suggest that this is an interesting example of Insoo using different ways of knowing.

Ways of knowing

I recently encountered the notion of ways of knowing in an article by Julia Jude (2016) in which she reflects on how she had learned to develop skills in talking in her training as a Systemic Psychotherapist and how this learning had required her to relegate other ways of knowing from her African heritage into the background. My curiosity was particularly aroused by Judes' view,

"*…when I look back on how ideas are taught in this field (Family and Systemic Therapy), I find they privilege European-American philosophical thinking.*" (pp 556-557).

This caused me to wonder whether I, in my practice, might also privilege talking over other ways of knowing.

Returning to Insoo's meeting with the young boy it could be said that different ways of knowing have been tried out – numbers on a scale, talking and finally drawing, which appears to have been the most useful.

If we want to know more about different ways of knowing we have some interesting places to look. I find the work of Howard Gardner (1993) on Multiple Intelligences a promising possibility. In his first publication Gardner lists 7 different intelligences – linguistic, mathematical, visual, musical, kinaesthetic, interpersonal and intra personal.

Many are familiar with the three rules of brief therapy

- If it isn't broken don't fix it.
- If it works do more of it
- If it doesn't work do something different. (for example Berg & Miller, 1992. p. 17)

Using Gardner's categories it could be said that when Insoo was trying to help the young boy figure out how he had made changes in his life she starts with a mathematical way of knowing. When this doesn't work Insoo tries a linguistic way of knowing. When this doesn't work Insoo tries a visual way of knowing and this helps the young boy notices significant differences in his life and actions on his part that fit with these changes.

In my own practice I still find that talking is enough to help many people make the changes they want to make. However, over the years, like Insoo, I have found that talking is sometimes a particularly difficult way for people to describe the life they want and what might already fit, and changing to different ways of knowing turns out to be much easier.

Case examples

In my current practice I make occasional notes as I go along, writing down key words and phrases the client has used and then read them out to make sure that the client is happy with what I've written. The client then has a copy of the notes to take away. In a workshop at the EBTA conference in Leewarden in Holland in 2014 I explained how this practice had emerged from three particular influences. The practice began when I took over the therapy with a young woman who had been seen by a student on placement. When I asked if there was any change to the practice she wanted the young woman shared that she hadn't liked the idea of the student writing notes about her after she left. In this moment of transfer from one professional to another the young woman drew attention to the power that professionals exercise when creating written accounts over which the client has no influence. Later on, by which time I was regularly taking notes during therapy sessions, a parent asked me what I was writing. When I read what had been written she asked why I had written what I had written in particular. This led on to what seemed to be an important discussion about what was most import to keep as a record of our meeting. The third influence was watching videos of Steve deShazer and Insoo Kim Berg. I had noticed that my own note taking sometimes helped me to stay on track with what the client wanted and think of solution-focused questions when the conversation became problem-focused. Although I never had the chance to ask, I wondered whether Insoo and Steve's note taking had helped them in similar ways.

In the workshop I presented several examples of how writing, as a way of knowing, appeared to have been important to clients. In one example I described an interesting moment in a session with a man with a history of depression who came for help with relationship difficulties with his partner. The man replied to solution-focused questions with ideas about small differences he would like to see in how he was at home. My impression was that these were novel ideas and so I took care to make a note of them. Noticing I was writing the ideas down the man commented, "That's really good. I should put that on my fridge so that I see it every morning." Concerned that he wouldn't be able to read my writing I passed the clip board to him suggesting that he write the ideas down so he could be certain he could read what was placed on the fridge. Interestingly

the words he wrote down were not only different from what I had written. They were also different from what he had said, which makes me wonder whether the act of writing worked as a different way of knowing. If so, then he would not be alone in such an experience as the following quote from Wittgenstein (1980) Illustrates,

"I really do think with my pen, because my head knows nothing about what my hand is writing" (p.17).

My second example is from a coaching conversation with a counsellor who had recently become the manager of a counselling service. The manager used the coaching to reflect on what would be regular meetings with the representative of the organisation that provided funding for the service. The purpose of the meeting was to monitor the extent to which the service was meeting key performance indicators. The manager was concerned that she had not been at her best in the first meeting and wanted to work out how to be better in the next. When I asked what she thought needed to be different, the manager recalled that in the first meeting she had mainly had her "counsellor head" on and that the next time she wanted to make sure she had her "manager head" on. Recalling a workshop on solution-focused body work by a colleague, Nigel Hetherington at a conference in my locality, I asked the manager whether it might be useful for her to show me what her body looked like when she had the different heads on and she agreed to try this out. With her counsellor head on the manager sat in a casual, open, posture. With the manager head on she sat upright with a clip board in one hand and a pen in the other. I then asked "Suppose you start off with your manager head on and you see signs of this being replaced by your counsellor head. What would you notice and what action would take you back to having your manager head on?" When I asked in a later session how helpful the solution-focused body work had been, the manager reported that she was much happier with how she had performed in the next meeting with the person in question. She also went on to say that she had subsequently used this knowledge to help her carry her manager head in many other situations to good effect.

My third example is from my work with a young woman who came to counselling to improve her motivation and find more ways to cope. The client had a history of anxiety and depression and was worried this was coming back. As a freelance practitioner I no

longer have my own room to see people in and have had to think carefully about which materials to carry with me. One particular graphic I always have copies of is of bears in a tree, which was produced by Heinrch Dreesen & Manfred Vogt Spielverlag from NIK in Bremen and shared at the EBTA conference in Leewarden in Holland in 2014.

When I asked about best hopes and times when these were already happening, the client shared some descriptions, but I wondered if the client might be able to know even more about what she wanted and thought the bears picture might be useful. When I asked the client where she was now she pointed to the bear towards the bottom on the left who is hanging on with his paws. When asked where she would like to be, she pointed to the one above who is standing on a branch and, she thought, looking confident. When I asked what would be the smallest sign that she was being more like the second bear she was able to describe more than she had described before. At the end of the session I gave the client a copy of my notes as I usually do. To my surprise the client then asked if she could take away a copy of the bears picture. As this was the last time we met I have no way of knowing what the picture contributed to the client's hopes for her life. Knowing how useful therapeutic documents, inspired by the work of Michael White (1995) have been to other clients, I expect that the picture will have played some part, and was at the least valuable enough to the client for her to want to have her own copy.

New influences from the world of philosophy

A number of prominent people in the solution-focused field, for example Mark McKergow with his Hessian research project (Hessian) and Guy Shennan are now pointing us to some different sources of inspiration from the world of philosophy. These are known as embodied cognition and the enactive mind. A recent edition of Interaction, is a special edition with interesting papers exploring how these approaches might help us make better sense of our Solution-Focused practice. A paper by Guy Shennan (2016), in particular, considers how these approaches might encourage us to use what I am thinking of as other ways of knowing, as Insoo did in her work with the young boy, and as I did in the three case examples above.

Shennan comments,

"Such a conception of the person might also call for an extended, flexible and shifting type of therapy…a therapist who uses pen and paper, artwork and other artefacts that could be recruited to aid the client." (p.25)

In the paper Shennan also reflects on the potential usefulness of music and the use of bodily approaches. Towards the end of the paper Shennan concludes,

"It can only be helpful to stretch our ideas of the personhood of the client, the client's world and of therapy" (p. 26)

Conclusion

"More than Miracles" (deShazer & Dolan 2007) was an important opportunity for the authors to take stock of how SFBT had developed over the years since the group at BFTC published the seminal paper on SFBT (deShazer et al 1986), with a title deliberately chosen to honour the influence of the MRI group. Many have continued to refine the approach. Chris Iveson and Mark McKergow (2016), with an article title chosen to mark a shift from solutions to descriptions, helpfully share the even simpler ways they have found to have solution-focused conversations. Whilst I, too, find that these simpler ways of talking can often be very helpful, I have also been finding that on occasions other ways of knowing might be more helpful than talking. Now that we have not only Wittgenstein to turn to make sense of what we are doing, but also the philosophies of embodied cognition and the enactive mind, there might be many other possibilities for useful solution-focused work as well as talking, and sometimes instead of.

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SCOPE OF SFBT: A REVIEW BASED THEORETICAL OVERVIEW

Fathima Shabnam & Jaseem Koorankot

Solution focused approach has been developed as a strength based approach that focuses on the strength and resources of the client and gives all the power to fix their own problems. By asking the hypothetical solutions, miracle questions and inquiring about exception to the problem, Solution Focused Brief Therapy (SFBT) focuses on the solutions, but giving little consideration on the history of the problem. In SFBT, therapists help clients find alternatives to current undesired state, which are believed to be within the clients' repertoire or can be co-constructed by therapists and clients. SFBT emerged in 1980's when de Shazer, Berg and their colleagues at their Brief Family Therapy Centre, Milwaukee started using their insights of carefully observing the cases to find out what was useful during therapy such that the client, rather than the therapist, was in charge of deciding the goals of the therapy and what worked in a successful therapy. Shazer and Berg did not believe that one need to know the origins of the problem to resolve the problem.

SFBT has become a widely used approach in a broad range of contexts, including schools and family settings, and individuals, professionals and community members (Corcoran & Pillai, 2007; Kim & Franklin, 2009). However an approach must be evidence based for the therapists to use it and for clients to know whether the approach being recommended is effective. The past studies done on solution-focused approach have brought out much evidence for SFBT as an effective intervention and the research on the same are still growing, with recent studies using more rigorous research designs. An attempt has been made here to go through the vast literature on SFBT and a few relevant studies that demonstrate the effectiveness of solution-focused models in diverse settings are discussed.

While evaluating the effectiveness of an intervention, meta-analysis study is considered to provide the strongest evidence followed by experimental design studies. A meta-analysis inquiry by Stamps et al (2006) through 21 international studies including 1421 clients indicated that SFBT does not have a larger effect than problem- focused therapy. However they found that it produces a positive effect in less time and its technique of letting the clients chose their goals and solutions tend to provide more autonomy to clients when compared to other traditional methods of psychotherapy. SFBT was also shown to have best results for personal behavioral changes. Kim (2008) conducted a meta-analysis on SFBT examining 22 studies in three categories namely, externalizing behavior problems, internalizing behavior problems and family and relationship problems. He found small but positive results, especially for internalizing behavior problems like depression, anxiety, and self-concept.

In addition to meta- analysis studies there were systematic reviews analyzing a large number of outcome studies, which had brought a comprehensive picture about SFBT. In the first systematic review done by Gingerich and Eisengart (2000), 15 outcome studies were identified and the conclusion drawn from those studies was that there was preliminary evidence for the effectiveness of solution-focused therapy. Corcoran and Pillai (2009) in their comprehensive literature review found that SFBT was effective in a range of therapeutic conditions including suicide prevention interventions (Rhee, Merbaum, Strube, & Self, 2005), marriage counselling (Zimmerman, Prest & Wetzel, 1997) and criminal offending (Lindforss & Magnusson, 1997). Gingerich & Peterson (2013) conducted a qualitative review of 43 controlled outcome studies on SFBT and concluded that SFBT is an effective approach with many different psychosocial conditions with children and adults. The strongest evidence for effectiveness of SFBT came in the treatment of depression in adults and reviews supported the finding that SFBT was briefer and less costly than alternative approaches. Bond et al (2013) in their systematic and critical evaluation of 38 studies in SFBT with children and families provided tentative support for the use of SFBT, particularly as an early intervention when presenting problems are not severe.

Studies that establish SFBT as a valid tool to treat the problems related to children and adolescents were also immense in literature. In a study done by Zimmerman et al (1996), SFBT was used to demonstrate the improvement of the parenting skills of parents of adolescents. For comparing the effect of SFBT, a group of 30 parents received SFBT, while a group of 12 parents were put on a wait- list control list. The parents in the SFBT group showed more improvements than the control list. Triantafilou (1997) demonstrated that

SFBT reduces behavior disorder symptoms in children, while Littrell, Malia, & Vanderwood (1995) demonstrated SFBT was helpful in assisting high school students to improve mood and meet goals. Daki & Savage (2010) evaluated the effectiveness of SFBT in addressing academic, motivational, and socio-emotional needs of children with reading difficulties and the results proved that SFBT could improve children's listening comprehension and reading fluency.

Newsome (2004) conducted a study involving at-risk junior high school students, in which he demonstrated significant improvements in grades of experimental group who received SFBT when compared to that of control group. In a study with obese children, the families of obese children received solution-focused family therapy and the post session tests implied that there were significant improvements in weight loss, self- esteem and family climate (Novicka et al., 2007). Another study that evaluated, and supported the effectiveness of SFBT within a classroom setting was conducted by Franklin, Moore, & Hopson (2008), confirming that SFBT is useful in improving the externalized and internalized behaviors of students. Corcoran (2006) in her study used SFBT to treat children with behavior problems and the results of the study indicated that there were higher treatment engagement in SFBT group when compared to the other group who received 'treatment as usual'.

Springer et al. (2000) in his study involving hispanic children of incarcerated parents, five students were given six sessions of group treatment using solution-focused, interactional and mutual aid approaches while another five students were treated as waiting list controls. The study could demonstrate that self-efficacy of these children could be increased with solution focused approach. Various other studies explored and demonstrated SFBT's effectiveness in reducing recurrence of child maltreatment (Antle et al., 2009; Corcoran & Franklin, 1998); in providing a supportive structure for first sessions with parents of children with learning disabilities and improved goal setting for families of children with behavior problems (Lloyd & Dallos, 2008; Adams et al., 1991); in improving coping of families undergoing divorce (Ziffer et al, 2007); and in improving functioning for young people with developmental difficulties, for example improved signing of a hearing impaired child (Murphy & Davis, 2005; Thompson & Littrell, 1998).

A number of outcome studies have been done to demonstrate the application of SFBT in clinical setting. Chung and Yang (2004) conducted a study in which solution focused group counseling was provided to the experimental group of families with schizophrenic

patients. After eight group sessions post session measures revealed significant reduction in family burden and expressed emotion in the experimental group when compared to control group. A study done by Wettersten et al. (2005) explored working alliance and therapeutic outcome, and showed that six sessions of SFBT produced significant improvement in psychological symptoms. Eakes and colleagues (1997) demonstrated the effect of SFBT in schizophrenic patients and their families. A control group of clients and their families received traditional outpatient therapy, while an experimental group of clients and their families were treated with a SFBT model. The SFBT group showed significant improvement in expressiveness, active-recreational orientation, moral-religious emphasis and family incongruence than control group.

Lee et al. (2001) used SFBT in the treatment of depression and post-treatment measures as well as follow-up measures after six months showed that there were significant improvements in the symptoms. Hanton (2008) studied the effect of SFBT on seven depressed adults and the Beck Depression Inventory scores were found to have an improvement by an average of 55.12 per cent in the post session measures. In the case of specific populations, a study conducted by Estrada and Beyebach (2007) demonstrated significant differences in pre-post test scores on the Beck Depression Inventory-II (BDI-II), indicating that the SFBT treatment was effective in reducing the depressive symptoms of people with hearing impairment.

SFBT has also been used to treat other groups such as problem drinkers (Berg and Millers, 1992), survivors of sexual abuse (Athood and Donheiser, 1997) and also in reducing domestic violence (Milner, 2008). Lindforss et al (1997) demonstrated the impact of solution-focused therapy in prison. In their study involving 30 prisoners in experimental group and 29 in control groups a follow up after 16 months showed that 60 per cent in the experimental group reoffended comparing to 86 per cent in the control group. It was also reported that there were more drug offenses and more total offenses in the control group than in the experimental group. In a study done by Rhee et al (2005) used brief telephone psychotherapy with callers to a suicide hotline. The callers either received solution-focused therapy or common factor therapy and some were in wait list control group. Both the treated groups showed significant improvements on post measures. Roeden et. al (2012) conducted a controlled study in which people with intellectual disabilities received either solution focused brief therapy or care as usual (CAU). The SFBT group performed statistically significant better than the CAU group on psychological functioning, social functioning, maladaptive behavior, autonomy and social optimism. Cockburn et. al (1997) used Solution

focused group therapy for orthopedic rehabilitation in a work hardening program. Results indicated that 68 per cent in experimental group were at work within 7 days while only 4 per cent in the control group went back to work within the same time period. A randomized study compared the effect of solution focused versus problem-focused coaching questions concerned with a real life problem that the participants wanted to solve. Solution- focused questions produced a significantly greater increase in self-efficacy, goal approach, and action steps than problem-focused question (Grant, 2012).

Indian practitioners have also begun to adopt solution-focused approach in clinical settings. However literature review indicates very less studies published in solution-focused approach, some of them being discussed here. Koorankot et al (2014) used SFBT to treat nine clients with depressive disorder who belonged to tribal community. Beck Depression Inventory scores decreased significantly in the post session measures indicating that SFBT was effective in reducing the depressive symptoms in the clients. In a case study by Reddy et al (2015) SFBT was shown to decrease the depressive symptoms and increase scholastic performance of a19-year old girl.

There is growing evidence that SFBT is briefer comparing to other psychotherapy techniques. Clients can be treated sufficiently with SFBT, without much elongated and elaborative diagnosis (Gingerich & Peterson, 2013). A comparative study between a single session of SFBT versus interpersonal psychotherapy among 40 college students indicated no significant difference between the two treatments, demonstrating that single session SFBT was effective in reducing depressive mood (Sundstrom, 1993). Lambert et al (1998) reported a treatment comparison study using OQ45, a self-report questionnaire measuring changes in symptoms, relationships and social functioning resulting from psychotherapy. The comparison study between 22 cases treated with solution focused therapy and 45 cases treated with psychodynamic psychotherapy revealed that both methods achieved 46 per cent recovery. The difference was that when solution focused therapy achieved the results by the third session psychodynamic psychotherapy took 26 sessions to achieve the same results. Littrell et al. (1995) in his study involving three treatment groups gave a problem- focused session followed by a task to the first group, second group received a session about the problem without task being followed and the third group was given a solution-focused session. Results indicated that sixty-nine percent were better in all groups, but the solution-focused sessions were shorter than those of the other groups. It consumes less time and is cost effective, thereby making it a popular technique among clients and therapists.

Based on the review of studies in solution focused brief therapy, it can be concluded that there is strong evidence that SFBT is an effective treatment for a variety of psychological and behavioral problems and across varied fields such as educational setting, clinical setting, prison, family counseling, and work and psychosocial rehabilitation. Various comparison studies indicate that SFBT is a briefer and less costly therapy when compared to other alternative approaches. From the literature analysis, it can be said that number of studies on SFBT has steadily increased with its setting and group of people in question being varied. Studies done in India are very few, however, the trend appears to be positive.

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COACHING:
STARTING FROM A POSITIVE IDEAL

Berghuis, I.R.

Introduction

At the NHL University in Leeuwarden, the student makes a " personal development plans" (PDP) with the help of a mentor. The learning goals are described and the student adheres to this plan, and keeps track of what is achieved, and what still needs to be worked on. The focus of this plan is especially what is **not** mastered.

It is well-known in current literature, that a positive self image is seriously more inviting and motivating in order to explore new possibilities from within, than an insufficient, especially negative formulated self-image which the "PDP" plan suggests.

Advocating from the viewpoint of solution-focused theory, where the focus point starts from a different angle, namely "what possibilities, qualities and resources exactly are available?" Therefore, I wish to propose a different starting point for the career orientation program. To encourage students to work on their own learning goals and wishes, that are linked to specific competencies in their educational framework, it is extremely important that in the first place the student is coached to discover and identify his or her own qualities (Cauffman & Dijk van 2009). The student is able to describe qualities, possibilities and resources in a personal quality plan (PQP).

This plan should be replenished with new qualities the student acquires during his or her education. The career counseling teacher is able to subsequently coach solution focused (Berg & Szabo, 2007) to achieve a personal development plan (PDP), in which the personal quality plan (PQP) can be supporting in order to achieve goals. By asking questions that are geared towards the future and with additional scaling questions, the teacher is able to support the student with concise short learning goals to achieve the final goal of the education requirements. The student becomes activated, to work on his personal learning goals from within their educational program, with the assistance of his personal qualities. The student is encouraged by his own possibilities, recources and qualities to take renewed steps.

Therefore, the personal development plan (PDP) that is created in this manner fits better with the individual possibilities for the student and this plan can really become a personal plan.

Hereby the career coaching fits perfectly with the philosophy of inclusive education, where the prerequisites are the possibilities and talents of the student. Hereby it connects the diversity of needs for students with or without limitations. All students work on the same competencies, during their education, however they consciously use their own qualities, possibilities and resources to realize these competencies.
A positive start, and solution focused coaching, cares for the connection of the diversity, qualities and possibilities of the student.

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Education
1978 Bachelor of Education
1983 Post Bachelor Special Educational Needs
1993 Post Bachelor Video Home training
1996 Post Bachelor Intensive Ambulatory Family Treatment (for working with Multi problem families)
2003 MasterCourse Solution Focused Therapy
2010 Masterof Education/Special Educational Needs(various lecturers from abroad about solution focused education)

Employment before the NHL University
1978-1987 Teacher Elementary school and school for Special Educational Needs
1987-2004 Social Worker for Young People, Familie Worker, a Staff member, Chairman at the Works Council.

Employment at the Social Work Department at the NHL University
2000-present *Contract activities in Social Work department*
Trainer Post Bachelor Intensive Ambulatory Family Treatment
Co Designer Intensive Ambulatory Family Treatment course
Trainer Solution Focused Therapy for Family Social workers
Trainer Solution Focused coaching for lecturers in Holland and Suriname
Designer Training Solution Focused Therapy and Solution Focused coaching
2004-present *Bachelor of Social Work*
Lecturer/ Trainer/ International internship/ Organizing guest Lecturers/Staff member specialization Family Treatment
Trainer Solution Focused Treatment and Solution Focused Family Treatment
Designer Training Solution Focused Family Treatment
2009- 2013 *Master of Social Work*
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THE SOLUTION-FOCUSED BRIEF THERAPY THEORY DEVELOPMENT

Peter Sundman

Abstract

This presentation takes us on a short tour to the days when the theory of the solution-focused brief therapy (SFBT) was invented and from there evolved to the ongoing discussion of a solution-focused theory of today.

Solution-Focused Brief Therapy (SFBT) is based on over thirty years of theoretical development, clinical practice, and empirical research. SFBT is a highly disciplined, pragmatic approach rather than a theoretical one. The developers have observed hundreds of hours of therapy over the years, carefully noting the questions and client's answers, behaviors, and emotions that led to clients conceptualizing and achieving viable, real-life solutions. The questions that proved to be the most consistently related to clients' reports of progress and solutions were carefully noted and incorporated into the approach, while those that did not, were eliminated. Today SFBT can be defined as a, client-directed, interactional, competency-based, future-oriented and goal-directed approach.

This pragmatical and theoretically limited stance has been and still is revolutionary compared to traditional psychotherapeutic approaches that operate on theoretical assumptions about the human mind, development and problems. SFBT is also different in giving special attention to and respect for the client's own descriptions, personal needs and goals compared to more traditional emphasis on hypotheses, diagnoses and strategies. This strategy has enabled developers and practitioners to come up with new and novel applications and practices in many professional fields. The lack of a traditional academic theory has however had the consequence that SFBT has had difficulties in getting recognition especially within the mental health field.

After the passing of the founders Steve De Shazer, Insoo Kim Berg and other pioneers, the next-generation SFBT-therapists have continued to develop the approach and looked for other theoretically and ideologically related approaches and thinking. Several have

been found and these are now under consideration to be tested and maybe used as theoretical references.

There are also several solution-focused developers trying to define SFTB in a more coherent and maybe traditionally theoretical way. I will end today by presenting some of these ideas. Ideas that will be discussed further during the SF World Conference next September.

Is there any SFBT theory?

Many SFBT trainers, like myself, have heard the founders refuse to give explanations to why the interventions work and how to explain them. Both usually parts of a theory. They also claimed that they didn't treat common problems like depression known in other theories. This has resulted in that SFBT has remained more of a bundle of ideas and practices than a well-defined fact (Miller & de Shazer, 1998).

Yet, from the first chapters of the first book to last, there are different theories explaining how SFTBT works. Each of de Shazer's five books has, for instance, 3 to 5 chapters on theory (Bavelas & Korman 2014).
Apparently he and others wanted to make clear that their work was different and designed for a specific context (ibid). This ascribes to the social constructivist notion that interaction is best described within certain contexts or as Wittgenstein puts it as 'language games', parts of an activity or form of life (de Shazer&Dolan 2007).
Secondly especially de Shazer thought that theories should be like maps that describe something, not prescribe something. Diagnosis was for them only constructions of the users. He also thought that a theory would start to lead the focus away from what clients actually say and do to what the theory suggests is happening.

MRI Brief Therapy Center 1967-

The development of SFBT started 1966 at Mental Research institute Brief Therapy Center (MRI) in Palo Alto, USA. Eight year later the team published a paper describing their interactional model (Weakland etal 1974) Their model was derived from the revolutionary book 'Pragmatics of Human Communication' (Watzlawick etal 1967). Mental problems were in this book shown to be interactional and maintained in behavior by those involved. Consquently the MRI model found a way in which the problems could be solved by changing the behavior in problematic situations. They described their model

as ‘a general view of the nature of human problems and their effective resolution’ (Weakland etal 1974). – Sounds actually like quite a grand theory.

‘Our fundamental premise is that regardless of their basic origins and etiology the kinds of problems people bring to psychotherapists persist only if they are maintained by ongoing current behavior of the patient and others with whom he interacts ... if such behavior is appropriately changed or eliminated, the problem will be resolved or vanish...’ (ibid). They go on writing that only minor behavioral changes or its werbal labeling often are sufficient to initiate progressive development. The therapist’s primary task is to take deliberate action to alter the poorly functioning patterns of interaction as powerfully, effectively and efficiently as possible (ibid).

Situational difficulties – problems of interaction – outcomes of everday difficulties, usually involving adaptation to some life changes, tha have been mishandled by the parties involved (and only somentimes fortuitous life difficulties) This leads to involvement of other life activities and relationships and symptom formation results. People with chronic problems have been struggling inappropiately for longer periods of time. overemphasis often related to utopian expectations of life (there must be an ideal, ultimate solution to everyday problems or underemphasis (denial of manifest difficulties). Some of these depend on more general cultural attitudes and conceptions.

Constructivism 1984 –

The book ‘The Invented Reality’ edited by the MRI team member Paul Watzlawick in 1984 reinforced the idea already used by the MRI team and to some extent the BFTC team that what we percieve as our objective reality is actually subjecitvely constructed in interaction with the environment (Watzlawick 1984). This idea has later become more known through an application in social interaction called social contructivism (Berger & Luckmann 1966). Social constructivism shows how the reality also changes with life experiences, which makes the process interesting for therapy.

The MRI team used this idea both in their so something different intervention and in reframing expressions and situations, especially when people didn’t want to do somenting different in the problem situations, because what they were doing made sense to them. This sense was usually reframed by the therapist as the rationale to do something different (Fisch & Schlanger 2001). In reframing the therapist suggests another concept, emotional setting or viewpoint to a client’s experience of a situation that places it in another frame which fits the client’s facts equally well or even better and thereby changes its entire meaning (Weakland etal 1974).

The following invented case example illustrates the MRI approach:

T: What problem has brought you to see us/me?
C: I have problem with my health, at work and with my family
T: which is the most important?
C: I think I am quite depressed.
T: What would you like to do differently?
C: I'd like to take care of my health, my family and work.
T: How have you been trying to take care of those?
C: Well, I try to get treatment for my asthma. I try to care for the family and work as much as I'm able to, but it feels like too much. I don't manage and get depressed.
T: Trying is obviously important to you?
C: Yes, I can't bear feeling like a looser, if I can't keep up to my obligations.
T: So, maybe doing something different would help?
C: Well, yes, I need to do something.

Brief Family Therapy Center BFTC 1978 - 1987

The BFTC team in Milwaukee, USA, is best known from the writing and teaching of Steve de Shazer and Insoo Kim Berg, but the team has had about twenty skilled practitioners and reseachers and therefore their model had different variations.

They started their deleopment from the MRI model in 1978. The team had a unique way to research and develop their work. Each week their 'research team' would look at tapes with something interesting, maybe new and potentially useful. They tried to analyze what was going on. If they found something new, they tried to use it with other cases, watched the results and if they were useful too, they could ask other team members to try out the new idea. They could then organize a study where the idea was systematically studied with more cases. This way the question 'notice what you want to continue happening' and the miracle question, for instance developed.

Quite early they discovered that solutions could be constructed from exploring what clients already were doing well. They started to call them exceptions. Something the MRI team sometimes used, but didn't often find, because exceptions are rarely obvious. In order to 'find' them you need to listen for clues about them and then carefully ask about them. As they tested out the usefulness of exceptions, they found out that people had strenghts and resilance that also could be used in coping and building solutions (DeShazer & Dolan 2006).

The BFTC team gradually shifted their attention from designing interventions for clients to a more collaborative relationship with clients. This was possible, because supporting people to do more of what they already were doing, helping them to achieve their goals for therapy and using clients' expertice all supported a common ground with the therapist. In the beginning they called it a 'ecosystemic' approach. The therapist became a part in the client's life. Later they found out that a 'fit' with what the clients were thinking was enough. So, no motivation was longer needed and no resistance occurred anymore (ibid). Clients were doing their best to cooperate and the therapists too following Erickson's tradition of utilizing whatever the client brings in.

They also tried to formulate a theory for the change work they were doing to explain in more general terms how the change happened. One of the best early explanations came from Buddhist philosophy; Change is constant. Stability is an illusion. Any new or different behavior can be used as part of a therapeutic solution Any difference can be used as part of the therapeutic construction of a solution. It only has to percieved or interpretad as a useful difference. This is what the therapist can do and thus become a part of the solution, they wrote (Nunnally etal 1986).

Building a better future – Solution building 1988-2007

The focus on constructing solutions with questions like ' How will your life be after this problem is solved?', transformed their model into building a better future instead of solving problems.

After this shift the old ecosystemic concepts no longer seemed valid and– How could the questions like 'notice what you are doing that ..' be explained? - after some search the concept 'fit' came up. Standard tasks only need to fit well enough to open the 'door' to a more satisfactory future for the client. This idea lead to the development of the' Briefer' computer model - a standardized procedure with their key questions as a decision matrix. This was interesting since it suggested that some form of standardized procedures were possible. During my training at BFTC the Briefer model gave in 70-80% of the cases a similar class of intervention as the team proposed. The therapy sessions done at that time also had a fairly unified structure.

Some members didn't however like this standardized model. They left, thinking it was too structured and limited. Family dynamics and feelings were, for instance not a part of this model anymore (Nunnally 2004, Lipchik Eve 2011). The development at this time, and later too, highlights the impact of the Ochams razor principle the developers used. Rather than looking at all factors that influence, they were looking for those most

consistently influencing the outcome and discarding the rest. This simplified the model considerably.

During this time the BFTC team became interested in how communication as an interpersonal process changed meanings. How words were constructed or invented through how they were is used in social interaction (DeShazer 1988). Through this interest they found that the language for solution development is different from that of problems. The language of solutions is more positive and hopeful. With less historical, behavioral and social resteraints, a much happier future where people are more architects of their destiny is possible to invent with clients (de Shazer&Dolan 2007). This is one way to explain why the miracle question is so powerful.

This interest in how the interaction and language changes people lead the BFTC team to an old 'friend', Janet Beavin Bavelas. She had been the secretary for the original ground braking book 'Pragmatics of Human Communication' in 1967. After that she made an academic career in analyzing professional conversations at the university in Vancouver. There she developed 'micro analysis', which is a special version of conversation analysis. One of its specialities is that she and her team used video taped converstations throughout of the analysis instead of transcribing them as many other reserachers do. She was happy to analyze BFTC tapes together with the BFTC team and continued to collaborate with other SFBT researchers after Steve's and Insoo's passing. These analysis gave further evidence of how change is happening in a dialogue through processes like 'grounding' presuppositions in questions, formulations, preserving and introducing topics etc (Froerer 2013). Looking at dialogues in such a detail has made it even more clear how even subtle changes in wording, timing, gestures and prosody make the change in therapeutic conversations.

The following invented case example illustrates the BFTC approach:

T: How can I help you?
C: I have problem with my health, at work and with my family
T: Ok, and what will tell you that coming here today was useful for you?
C: Well, If I somehow would get energy to start to sort out these problems, but now I'm so tired, maybe even depressed.
T: So, this getting energy to sort out the problems would be helpful?
C: Yes, energy and not getting exhausted.
T: When was the last time you had this energy tha prevented getting exhausted?
C: I gues it was before my asthma got worse and maybe when I had an easier job.
T: What did you do differently at that time?
C: I think I had more strenghts and the work was easier.

T: What else?
C: Maybe I also took more often one thing at a time and not like know try to do everything at once. It's just so difficult when things have piled up.
T: Could it help also now to take one thing at a time?
C: I guess it would.

LTI Openness and brainstorming 1986-

In comes Ben Fruman and Tapani Ahola from Helsinki, Finland. They started their Lyhytterapiainstituutti (LTI) training institute in Helsinki in 1986 and soon discovered that the setup with a team behind the mirror and a therapist working with the family was too complicated to use and against the egalitarian values in Finland. Having unknown people watching and evaluating you doesn't fit well there (it is actually a strange setup in most part of the world). Instead they started to have all people present to sit in one room and participate in the therapy (Furman 1990). As a bonus they got rid of technical and organizational problems as well.

This lead to new collaborative questions. How organize up to twenty people to act together? The best practice turned out to be 'brainstorming' together. Brainstorming meant that several options for directions, possibilities and solutions were discussed with the clients, giving them more possibilites than those they initially had in mind. This setting made it easier to invite more people from the clients network, which turned out to be beneficial compared to the BFTC stance of settling with whoever turnes up. From these experiences they added two components to the model. To utilize 'supporters' and to talk about the benefits of achieving the solution, which highlighted clients' motivation and values important to them (Furman&Ahola 1992).

The following invented case example illustrates the LTI approach:

T: What would you like to have happen as a result of coming here today?
C: Well, I need help to deal with my health, work and family problems.
T: And getting help to deal is for you...?
C: ...somehow getting stronger and having more energy to take care of them.
T: How important is that for you at the moment?
C: Very, because now I feel like a looser and others have to do what I should do.
T: Who are these others?
C: My children and my colleague, who does some of my work now.
T: If you think of getting stronger and having more energy as a skill, what skill is it you like to use more?

C: Well, I guess, because I now have less energy than before, I need to learn how to do one thing at a time or do them more superficially. Maybe also let others help a little bit.

BRIEF best hopes 1989

Another interesting path of development during the last 20 years has been done by the BRIEF team in London. They started from the BFTC model and gradually moved to a stance even further away from problem connections by directing the interaction towards client's 'best hopes'. Instead of asking "What brings you here?" which elicits a problem account. They began to ask "What are your best hopes from coming here?" which invites the client to specify an outcome from the start (McKergow &Iveson 2016). Some clients answered without reference to problems. Without knowing the problem it was impossible to ask for exceptions, so the second question became a variation of the miracle question eliciting a description of the client's preferred future. Exception questions were then replaced by finding instances of the preferred future already happening (ibid).

Conceptually 'best hopes' seems to lie somewhere between next steps/goals and miracles. They have said that asking and elaborating on client's goals, exceptions and miracles all are related to problems while best hopes don't need to be. One can have best hopes without problems (ibid). Asking about best hopes is also contextual in that client take into account what they percieve as possible in the situation at hand. These questions, with the presupposition that they will achieve them, also ask for descriptive answers. They also continue the SFBT tradition of exploring behavioral and relational issues.

BRIEF has reported that their model has shortened the therapy process and has made the therapist more insignificant and helped the therapists to avoid becoming stakeholders in the clients lives. The credit for progress is easy to give to the client (ibid).

The following invented case example illustrates the BRIEF approach:

T: Can I start with just asking you what your best hopes are from coming here today?
C: Well, I hope I could take better care of my family, myself and my job.
T: Ok, so assuming that happens, coming home from here or going to your work, how will you know that's happened?
C: My children will for sure notice, because then I'll start cooking and asking them how their day has been.
T: Ok, what else?

C: I'd probobly make an appointment to a doctor to get help for my asthma.
T: And how will your workplace know?
C: My colleague will see me doing my work instead of complaining how tired I am.
T: How will your children react when you come home and start cooking and talk with them?
C: I think they will be happy and play more together instead of fighting.
T: How will that do for you?
C: That makes me happier and maybe gives me a boost to do some more.

The bigger picture 2007

The Occham's razor principle that many SFBT researchers have used, lead them to narrow their focus of attention and primarly looking at their own work and concequently maybe leaving out interesting and useful ideas.

After Steve's and Isoo's passing, Gale Miller, Mark McKergow and Michael Hjerth started discussion groups in Europe to look if there were other theories around that could be interesting to learn from and help to develop SFBT further.

Positive psychology research into positive emotions is of interest to SFTB theory because the research shows that posivite emotions have a great impact on problem solving and reciliance (Fredrickson 2013). The research also provides SFBT therapists with words for possible client experiences that the client may have difficulty in putting into words. – With the risks of undue therapist influence on clients of course.

Fredrickson (2009) has named ten most common positive emotions to be joy, gratitude, serenity, interest, hope, pride, amusement, inspiration, awe and love. Experiencing these 'broaden the scope of attention, the scope of cognition and the scope of action. They build psysical, intellectual and social resources and make people more resorceful and resiliant (Fredrickson 2009). She suggests that they make people more flexible, attuned to others, creative and wise (Fredrickson 2013). Some of what she writes seem similar to what the BFTC team refer to as 'ceating a postive frame' 'giving compliments' and the LTI team call 'supporters', 'celebrating the success' and 'giving credits' (Furman &Ahola 1992). The concept of hope has also for long been a part of the SFBT vocabulary (DeShazer&Dolan 2007).

The TaitoBa team has incorporated the idea of setting up and maintaining a 'positive atmosphere' for and with the clients. Something most SFBT therapists actually do, but don't pay attention to. This is in practice to greet clients friendly, have what hopefully is

a nice meeting place. Talk about client skills and knowledge, build upon client induced humour, reflect on and introduce more positive feelings if the therapist feels it could be useful. We have also started to name positive feelings if clients make reference to them and connect these references to desirable situations and the better future. Clients' reactions seem to be in line of what Fredrickson suggests.

SFBT strengths is in supporting clients' situational change; How to handle certain situations. Some clients also want to understand and change their life in more general way (McLeod 2006). A traditional reaction to this wish is to ask about where to start; 'What is the first step?'. Then after success to assume that the clients are capable of taking further steps by themselves: 'stay on track'. This might not be enough in all cases (Sundman 1993, Valkonen 2007, McLeod etal 2009).

One way to address these more general wishes is to link the situational change to how people in general make sense of their life with life narratives (Miller 2008, McKergow&Iveson 2016). This might involve ways to use interactional and interpretive methods to be involved in constructing, developing or maybe reconstructing clients' narratives? Maybe know more about how narratives project ongoing interactions into the past and future (Miller 2008)?. 'The more elements allowed into the story of our past the more possibilities we are likely to see in the future. Exceptions (to the problem story) and instances (of the preferred future story) both add new elements from which "self-understanding and self-shaping" can be drawn', McKergow and Iveson recently wrote (McKergow&Iveson 2016).

Video tapes from solution-focused therapists actually show how SFBT therapists make references to client's narratives like 'you must be a smart young man' or 'you seem to be really aware of what small, little things that happen in your family might make a difference' (DeShazer&Dolan 2006).

Some clients ask for explanations to their problems and wonder what they mean to them. The typical SFBT tendency to change this concern into behavior seems in some cases to be expert, not client focused. If we believe that people know what's best for them shouldn't we respect them in this expression too? Some SFBT therapist do talk about meaning, but this is not usually expressed in public (Chang etal 2013).

Something along this line has been done and researched in Northern Finland since the 1980s by Jaakko Seikkula and his team (Seikkula 2014) They developed 'Open Dialogues', an dialogical approach to acute psychosis. Theoretically their idea is based on the notion that words carry fragments of meaning and a more complete meaning arise

through an exchange of words (dialogue) with others. When a person is traumatized, his or her emotions become unbearable. It may be impossible to put the experience into words and the person has difficulty in understanding himself and in making himself understood by others resulting in symptoms of mental illness, even psychotic behavior. Psychotic behavior can thus be seen as people's way to communicate their experience of an overwhelming life situation for which they don't have any words. Through a dialogue between people within a social network, in which all voices are heard and given equal weight, and concentrated on what is important to those involved, a new shared language and understanding replaces the symptoms. This language builds up the network's inherent resources. With time, the crisis can become an opportunity for positive change: a chance to retell the stories, reshape the identities, and rebuild the relationships that tie the self to the world (Burton 2015).

From a solution-focused perspective the interaction that supports people in the social network to make sense for themselves is interesting. Could such an element in a solution-focused interaction make it easier to answer clients' why questions without transcribing them into behavior? Or would this weaken the strongest behavioral element of SFBT?

I have made trials with what I call a 'reflective' dialogue in my therapeutic work. Resembling the principles of open dialogues, I've reflected with clients and others present about alternatives (different voices), consequences, possibilities and differences before concluding what the goal, miracle, exceptions, doing more, doing differently, best hopes, next step or summary is, ie in all phases of the meeting and working process. It seems to me that the conclusions become more understandable for those present. They connect to some extent the situation at hand with people's narratives.

Could this furthermore be an extended version of reframing?! Reframing expressions and situations together and with time instead of the expert based instant reframing done before?

There are also several other theories with some fit to SFBT, like constructivism, perception theory, discursive psychology, pragmatist learning theories, phenomenology, agility theories, and even attachment theory, structural and normative as it is.

The 'why?' and functional explanations

de Shazer and others explaining the SFBT way of working were very particular about that they only wanted to describe how SFBT worked without any causal explanations. This can be called using functional explanations, which means giving account to an item by showing how it contributes to the system in which it occurs (French&Saatsi 2014). It's an old and accepted way of explaining causes in terms of function in relation to a desired outcome. - Maybe this is what the SFBT developers have been doing all along. Connecting theory and practice in a pragmatistic way. Observing what is going on and making sense of it. Then deciding what a good outcome could be and how get there?. After this trying out the proposed solution. Then evalauating and reflect on the result and the consequences. Finally adopt the new or better behavior (and explanation) (Dewey 1910).

McKergow and Iveson (2016) suggests that SFBT don't need any causal explanations, but instead descriptions of possible patterns how to influence. Therapists can try to listen to everything the client says, but they cannot respond to everything. They must select which part of a client's answer will be most useful in constructing the next question or other reaction. Therefore they need to have a coherent framework for making these selections.

Within the EBTA task-group assigned to work on a theory we have started to design such a framwork. It could apart from asking typical SFBT questions contain selection criteria like this:

- The therapist reacts from moment to moment on what the client does, concentrating on what he observes that can be associated with a positive future, doing well, strenghts or creating new alternatives.
- the therapist tries to bring into the dialogue differences that emerge related to what the client wants.
- The therapist helps the client to put expressed descriptions into perspective, for instance, what significance the change has and how she wants her life to be.
- The therapist all the time checks, modifies what he says until the client agrees to it.
- Therapists formulates what the dialogue has shown to be useful or could be useful for the client.
- The therapist is attributing agency to the client whenever possible.

Today and tomorrow

Today SFBT can be defined as a, client-directed, interactional, competency-based, future-oriented and goal-directed approach (EBTA 2012). The development however continues with different models and ideas. The differences might become bigger (McKergow&Iveson 2016).

BRIEF's model can be seen as new phase in the development of the solution-focused theory. Conceptually no longer has a connection to problems, nor to goals or exceptions. – This might be one way for SFBT to go forward.

There are other solution-focused developers, like the EBTA group I'm belonging to, trying to define SFTB in a more broader and maybe traditional way. Others have stayed close to the BFTC model (SFBT 2013). Some incorporate systemic and cognitive ideas (Isebaert 2017).

One key question today is still whether a descriptive theory is a good choice? – Maybe SFBT after all, could have some hypothetical causal explanations based on the concept of 'fit' from BFTC:s early days? It might be possible to use the client's explanatory theory that fits the situation. Scott Miller, a former team member from BFTC, has together with some other researchers shown the importance of the clients' theories (Duncan etal 2000).

Another type of 'fit' suggestion has been made by McKergow and Iveson to use the theory of emergence and narratives as explanatory theories (Iveson&McKergow 2016).

On the other hand SFBT might after all be more of a philosophical endeavour (de Shazer etal 2007) – Maybe it is still best described with the basic principles, maybe with the addition of one recent one:

Only fix what is broken - Do the changes you want.
If something doesn't work, do something different - Do more of what works

Some of these ideas will be discussed at the SF World Conference in Frankfurt, Germany, next September. After that we know more of the SFBT's theoretical stance.

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Peter Sundman is trained by the Mental Research Institute in Palo Alto and the Brief Family Therapy Institute of Milwaukee, USA in the 1980's. After that he collaborated with John Weakland, Karen Schlanger, Elam Nunnally, Steve De Shazer and Insoo Kim Berg for many years and became one of the pioneers, who with their support brought the solution-focused approach to Finland. Most of his work has been within the social- and health care especially in child protection and family work, as he also has a background as a family therapist. One of his expertise is to apply relevant research in practical work contexts. Since 1990 he has worked as a clinical supervisor, trainer and consultant together with a team of solution-focused professionals devoted to innovations and learning. Peter works internationally through EBTA and its task groups. He has had numerous presentations at EBTA and other conferences and workshops in Europe and beyond. Currently he is collaborating with others to define a theory for the solution-focused practice and to mentor and train the next generation of solution-focused professionals.

CHAPTER II

ACCEPTANCE AND COMMITMENT THERAPY- A PRAGMATIC APPROACH TO BEHAVIOUR CHANGE

Minimol K Jose

Acceptance and Commitment therapy (ACT) (pronounced as the word 'act') is an evidence based psychological intervention which helps managing a wide range of problems.It is an empirically-supported mindfulnessbased cognitive-behavioraltherapy. This therapy is based on Relational Frame Theory(RFT), a school of research focusing on human language and cognition. RFT provides an understanding of the power of verbal behavior and language.ACT is also rooted in the pragmatic philosophy of functional contextualism (Hayes, 1993). Functional contextualism explains the role of context in understanding the nature and function of an event.

Major goals of ACT

- Foster acceptance of unwanted private experiences which are out of personal control
- Facilitate commitment and action towards living a valued life
- Increase psychological flexibility: the ability to contact the present moment and the psychological reactions it produces, as a fully conscious human being, and based on the situation, to persist with or change behaviour for valued ends

In other words ACT is to create a rich, full and meaningful life, while accepting the pain that inevitably goes with it.

The Acceptance and Commitment Therapy can be explained using a hexagon. There are six core pathological processes that correspond to the six core intervention processes. For the easy understanding of this therapy here in this article I would like to explain the ACT model of psychopathology and then ACT treatment model.

ACT model of psycho-pathology

The six psycho-pathological processes are:

1. Loss of contact with the present moment (preoccupation with a conceptualized past or future)
2. Cognitive Fusion
3. Experiential avoidance
4. Self-as-content (Over-identification with a conceptualized self)
5. Remoteness from values
6. Lack of committed action (Impulsive/ineffective/avoidant/'mindless' action)

Fusion: The client who is approaching the therapist would be fused with all sorts of negative thoughts, unhelpful evaluations about themselves and others, painful memories from the past,

Eg. I am bad, I don't deserve, I will never get better, I am tired etc..... Worrying, ruminating etc. are the manifestations of fusion.

Experiential avoidance: Experiential avoidance means "attempts to avoid thoughts, feelings, memories, physical sensations, and other internal experiences even when doing so creates harm in the long-run"

(*Hayes*, Strosahl, Wilson, 1999). Humans are tempted to try and avoid negative thoughts and emotions whenever they occur. And this is a strategy which can work extremely well in some contexts. For example, not going for a social gathering is a common way of feeling less nervous – that's experiential avoidance. But it can also interfere with more important aspects of life. Examples are putting of important tasks due to the discomfort it causes, not using opportunities to avoid fear of failure, not engaging in social activities because of anxiety etc. But this is a trap which always forcesthe person to move away from what he/she really wants to do. Experiential avoidance can work in the short term but it doesn't work in the long term.

Fusion and avoidance always go together. When people have depressive thoughts such as "I am not good", "No one likes me", "I am a failure", they also try to get away from such thoughts using other behavior such as drinking, smoking, over involvement in eating or other addictions.

Dominance of conceptualized past or future: Humans may spend a lot of time absorbed in thoughts about the past or the future. Instead of being fully conscious of present experience, we may operate on automatic pilot.Fusion and avoidance lead us to a loss of contact with reality or 'here and now' experience. It causes rumination over things that have already happened in the past and fantasize the future, anxious about what is happening next and in the meantime they miss out the life that they havein the present moment. They lost touch with their own psychological world and physical world in the present moment.

Lack of values clarity: People often forget their values and directions when they are fused with painful thoughts, trying to run away from situations causing discomfort and also absorbed by concerns about past and future. Eg.Depressed clients often lose their connections with the desire of their life and become incapable of contributing to others or being productive. They also neglect their health and well-being. Then the client is helped to understand the incongruence between the values and their current behavior or circumstances.

Unworkable action: Unworkable actions are patterns of behavior that keeps us away from a life that we really wantto live, and make our life even more miserable and painful. It is often impulsive activities that havean adverse effect on the quality of life e.g. excessive involvement in activities such as drinking alcohol, watching TV, eating, procrastination, attempting suicide etc.

Attachment to conceptualized self: We all have a story about ourselves, ie a description about ourselves, our past and also about our future. It could be positive or negative. When we fuse with these self-description, whether it is positive or negative it causes problem. Fusing with the self-concept that I am strong and independent creates high self-esteem, but sometimes it prevents people from asking or accepting help from others when they really need. When they fuse with negative self-description it affects theirself-esteem adversely and creates problems.

ACT model of therapeutic interventions

Before coming to the six core processes of ACT intervention we need to understand a concept called creative hopelessness.

In the case of clients who need behavior change, usually they come to therapist after attempting various techniques to manage the difficulties. In ACT the therapist helps

the client to examine the workability of those strategies. Many of those strategies may seem to be controlling, and trying to get away from unwanted feelings and experiences. This initial exploration in this direction helps client to realize the unworkability of those strategies in their context and the necessity of trying another one that could give long term benefits. In ACT terminology it is called 'creative hopelessness'. Actually this is the starting point of creating a space for a new way of dealing with the problem. This state is 'creative' as it prepares the person to use entirely new strategies.

Defusion: This is the opposite of cognitive fusion which we have seen as the first item in the pathological processes. This is about stepping back and noticing thoughts rather than being caught up with the thoughts. The aim of diffusion is to reduce the impact of unhelpful thoughts on us. It helps us to detach from our thoughts and evaluate or assess objectively. This helps us to understand how human language affects our self-concept and thoughts.

Acceptance: This is the antidote to experiential avoidance. It means making room for the painful feelings, emotions and experiences instead of fighting or resisting with them or let go of the discomfort. It helps us to live a value-directed life in the midst of pain and suffering. This will allow our feelings to come and go with a kind and open stance without draining us or holding us back.

Contacting the present moment (Mindfulness): Mindfulness allows us to being touch with the present moment. This means deliberately bringing our awareness in to physical world around us and to the psychological world within us. Instead of operating on automatic pilot this will help us to be here and now.Mindfulness allows us to engage fully in what we are doing.

Self as context:There are two distinct elements of life: the thinking self and observing self. Thinking self activates generating thoughts, beliefs, judgments, plans etc. The observing self is aware of whatever we are thinking, felling, planning etc. As we go through our life, there are a lot of changes occur to us such as bodily changes, our attitudes, beliefs etc. The observing self is the same throughout our life but it observes the changes in us as if it is someone else. The observing self makes us more human and this is more important for developing self-kindness and self-compassion.

Value clarification: Clarifying one's values is essential for creating a meaningful life. The therapy can start with clarifying the values of the client. This can be easily achieved through asking questions such as 'what matters you most in your life?' What gives

life meaning? or 'what do you want to do with your brief life time on this planet?' Valued Living Questionnaire (VLQ)(Wilson & Groom, 2002) can also be used to elicit values. This gives an idea about the client how he/she wants to behave in his/her day to day life. In ACT this is called 'chosen life directions', also called the 'compass' of life. It is important to know the difference between values and goals. Values are ongoing patterns of activity which can't be achievable or completed, but goals are achievable and completed. Values have transformational power and are reinforcing. In ACT the client is helped to understand the incongruence between the values and their current behavior or circumstances.

Committed Action: Translating values into congruent actions is the next process in the interventions using ACT. This means helping the client to set realistic goals to fulfilltheir values or live a life in our chosen direction. Under this section, the client will be helped to develop SMART (specific, meaningful, adaptive, realistic and time framed) goals. In order to fulfill the values of being a good dad, the person has to take committed action in the direction of his values.

ACT also requires a concrete therapeutic relationship or working alliance between the therapist and the client.

Conclusion

ACT is an effective alternative treatment option for many behavioral modifications. This therapy helps clients increase their social functioning and quality of life. Patients with psycho-social problems engage in a range of avoidance behaviours without understanding the fact that they only give short term benefits.

The advantage of ACT is using a number of metaphors, worksheets and exercises that anyone can easily understand.There is no ACT technique that therapists can use with every client. Even the terminology or nature of questions to elicit avoidance or personal values will be different for each client. Therapists need to be sensitive to the unique presentation and situation of each and every person they work with. Theorder of the treatment processes also will vary according to the nature of the problem of the client e.g. In the case of severe emotional problems due to experience of trauma in the past, the strategy diffusion to be used only after doing a lot of work around validating the pain, self-compassion, acceptance etc. Otherwise the client may think that the therapist has not taken their emotional state seriously and labeled as 'simple' or silly'.

It would be very effective if the therapists can use ACT techniques in their personal life and get convinced of the benefits before trying it to their clients. The more we apply the strategies in our life the better we will be able to use with our clients. This reminds us of the words of Mahatma Gandhi “Be the change that you want to see in the world”.

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PLAY - CATALYST IN CHILD PSYCHOTHERAPY

Sherin P Antony

Abstract

Therapeutic play techniques are sophisticated tools to communicate with the children and it enhances the therapeutic processes among them. Since children are in the learning phase of articulating their feelings, thoughts and behaviors adequately, play techniques facilitate the progression in therapy; the interaction between the therapist and the child, rapport formation, catharsis and changes in them. This presentation aims at slowly accommodating the idea of bringing an identity and recognition for play therapy with the cultural elements of different play techniques.

Introduction

Significance of Play in psychological therapies has been identified in Sigmund Freud's work with children (1909). Anna Freud and Melanie Klein dealt with children by integrating Free-Association and play techniques. Virginia Axline's "Dibs in search of life" (1946) fashioned an illustrious development in Play therapy.

Seven year old Priya has lined all her Barbie dolls in a row, the arrangement mimicking the classroom of her school. She has fashioned her mother's old dupatta like a sari donning the role of her class teacher. She has a colouring book in one hand and a red crayon in the other. Priya slowly walks towards the doll dressed in pink, hands on her hips and addresses it in a stern voice – 'Pinkie you need to improve your shabby handwriting! I am giving you extra homework to practise your cursive writing. If I don't see improvements I am going to call your parents!' And she vigorously circles the book in red.

In the case cited above we can observe how the young child has recreated her experience from the classroom which could have caught her attention. Psychologists have established that play therapy is of great therapeutic value primarily because it is a natural mode of self-expression.

Approaches to play therapy

Client focused approach

Non- directive play therapy, a client focused approach was developed by Axline.V by borrowing the concepts from Carl Roger's approach to therapy. This approach functions by an assumption that setting an opportunity for children to express their psyche freely through play would lead to better understanding of their intrapersonal experiences and resolve the conflicts in their own subjective world whereas Prescriptive play therapy focuses on specific difficulties among children and its therapeutic remedies through play.

Psychoanalytic approach:

Psychoanalytical perspective believes that the unconscious conflicts get expressed and experienced through the process of play. The perspective stresses on 'Free- Association' as a technique in adults, and the equivalent technique used with children is 'Play'.

Release and Structured play Therapy:

Structured play therapy sets a specific background with precise play materials where children may recreate the traumatic situations and release negative emotions associated with the trauma (levy, 1938). Through play, they assimilate the negative thoughts, feelings and emotions related to the same. During the session the role of the play therapist is to facilitate the emotional reactions and refrain from interpretation.

Family Play Therapy:

Family play therapy was proposed by Guerney (1964). It is a platform where the therapist brings in parents, grandparents, sibling and children in the process of therapy. The approach focuses on psycho-education to adults and strategies to deal with the difficulties among children. The therapy enhances the bond between family members and the child as well.

Cognitive Behavioral Play Therapy:

Knell (1993) proposed the concept of integrating play techniques and cognitive behavioral therapy. In this approach therapist has an active role to interpret for the client and to teach alternate behaviors or coping skills through play techniques.

Specific play materials used

A set of puppets exemplifying a boy & girl, mother& father, and Grandmother& Grandfather are appropriate in the play therapy room along with the animal puppets characterizing prey and predator. Few puppets which are neutral can be incorporated. Dolls in the play therapy room include human dolls, human- like dolls, anatomically correct dolls and ethnically varied dolls. Since the school is the second most important socializing place followed by family, a set of toys representing miniatures of schoolhouse, school bus, school children, teachers, and playground can add to the repertoire of toys. Nurturance materials are basically pretend food and miniature kitchen equipment. Incorporating creative materials like paper products, clay, clips, glue and drawing materials often useful during play therapy. One of the necessary materials in play therapy room is Sand tray with figurines to play out self-image and to project unresolved conflicts. Another useful material is soothing object. Stuffed toys, Pillows or soft blankets can be used as transitional objects in the play therapy room.

Play Therapy versus Therapeutic Play Techniques

Play therapy is a very systematic process wherein the children go through different phases of therapy over the course of treatment. They are recollection of memories, reconstruction of affective elements, re-experiencing the same with congruent expressions and resolution of the challenges through mastery of alternate behavior. And in therapeutic play techniques, they are chosen to deal with the specific challenges in children. Play techniques discourse different methods to deal with issues of Anxiety, Aggression, Depression, Social Dysfunction, Phobia, Attention Deficits, Mutism etc.

Evidence proposes that puppets and insulin doll was found to comprise projective and transactional utilities that gave children the authority to make decisions, express feelings to and through the doll, understanding the sites to take insulin injection and practicing it on the doll. Puppets help them to comprehend the task and dispel myths.

Conclusion

As psychodynamic approach to play therapy proposes that play is a platform wherein the child projects psyche: conflicts and defenses, techniques using sand tray, doll house and puppets facilitates the self-expression of conflicts and resolution of those through interpretation. Children use it to express pent up emotions and anxieties, satisfy unfulfilled desires, model behaviors observed or reflect upon newly encountered situations. Relationship theorists draw attention to self-respect and self-acceptance through many play therapy materials such as miniatures, nurturance tools, drawings and paintings. Behaviorists altogether took another perspective of disciplining or modification of behavior by using play techniques as reinforcements. Unfolding an integrated model of play therapy in Indian context to meet the quality of development of children in all the domains is essential.

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INTEGRATING MINDFULNESS AND SOLUTION FOCUSED BRIEF THERAPY IN PRACTICE

Aarathi Selvan & Baijesh A.R

Abstract

Mindfulness has been acknowledged as a trans-theoretical and trans-diagnostic approach to working with clients in psychotherapy (Germer et. al, 2013). It has been theorized and researched to be a model for clinical training to cultivate therapeutic presence (Fulton, 2013). The theoretical frame of reference of mindfulness has been seen as way to inform therapy (Shapiro and Carlson, 2009)and lastly the specific techniques of mindfulness have been used as interventions in therapy (Pollak et. al, 2014).

Solution Focused Brief Therapy is, as its name suggests, brief and focuses on solutions instead of problems. SFBT is a goal-directed, future-oriented and solution-focused model. According to Egan (2007) SFBT has moved away from focusing on clients problems, and pathology to focusing on clients competence and ways to uncover their toolbox of solutions. That is, SFBT helps clients identity the means to a solution based on their own goals, resources and strengths.

It is theorized that integrating Mindfulness as well as SBFT in therapy practice yields a therapy modality that enhances therapist's presence. The contextual and constructivist philosophies of the SBFT and Mindfulness allows for the focus to be on the present moment challenges as well as future-oriented solutions that help the client fully access his repertoire of skills. Further, the specific approaches of Mindfulness and SBFT enhance clients self-acceptance, lead to positive behavioral change, effective self-regulation skills thereby leading to amplified therapy outcomes as well as improved relapse prevention.

Introduction

Mindfulness has been acknowledged as a trans-theoretical and trans-diagnostic approach to working with clients in psychotherapy (Germer et al., 2013). It has been theorized and researched to be a model for clinical training to cultivate therapeutic presence (Fulton, 2013). The theoretical frame of reference of mindfulness has been seen as way to inform therapy (Shapiro and Carlson, 2009)and lastly the specific techniques of mindfulness have been used as interventions in therapy (Pollak et al., 2014).

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Mindfulness Oriented Psychotherapy

Mindfulness as Advanced Training for Therapists:

According to Germer et al. (2013) Mindfulness supports the development of a variety of qualities that help in establishing a strong therapeutic relationship such as cultivation of attention, compassion and empathy, therapeutic presence, self-attunement, openness and acceptance, dispassionate self-observation and self-insight, a broader perspective on suffering, nonattachment and a range of other factors.

Several meta-analysis studies have shown that across different modalities there is very little difference in outcome regardless of theoretical orientation due to common factors across modalities (Norcross & Wampold, 2011). The qualities patients attribute to therapist in positive treatment alliances include empathy, warmth, understanding and acceptance, positive regard, collaboration and consensus.

Germer et al (2013) theorize that the practice of mindfulness helps the therapist cultivate a nuanced ability to pay attention. This entails two different aspects. One is the ability to focus attention quickly and sustain this focus on the chosen object and the other is to have control over deployment of attention during the session, so that attention is equally distributed to stimuli that is being presented by the client in the session. Lazar et al. (2005) demonstrated that mindful meditation has shown greater cortical thickening in areas associated with sustained attention and awareness. This goes to show that the therapist's mindfulness practice will support his/her ability to stay attentive to the client, a skill essential in the therapeutic encounter.

According to Shapiro and Carlson (2009) mindfulness allows us to distinguish between the cold, hard, clinical aspect to attention, from attitudes, summarized by Kabat-Zinn (1990); Segal, Williams, & Teasdale, (2002); and Shapiro& Schwartz (2000), of non-attachment, acceptance, letting go, beginner's mind, non-striving, non-judging, patience, trust, warmth, friendliness and kindness that could significantly enhance the therapeutic relationship.

Germer et al (2013) posit that mindfulness cultivates witness consciousness or observing ego (that accepts experience without judgement). Further, that witness consciousness leads to self attunement (in touch with inner experiencing), and this leads to self compassion and compassion for others (Same neural circuitry for self and others, leading further to self regulation (realization that our suffering is not unique). Self-regulation is an essential quality for both the therapist and the client and mindfulness allows for the development of the same.

In using mindfulness practices of attention, open-monitoring and loving kindness as advance training for clinicians the therapist is able to integrate mindfulness in their presence with the client. We are of the opinion that this allows for an enhanced therapeutic encounter in clinical settings.

Mindfulness Informed Psychotherapy

Mindfulness-informed psychotherapy is a relatively new approach to integrating mindfulness and psychotherapy (Shapiro & Carlson, 2009). Mindfulness is based on basic tenets of impermanence, the concept of no-self, accepting what is, conscious responding versus automatic reactivity, curiosity and investigation, paradox, interdependence and essential nature. The authors Shapiro & Carlson (2009) specify that Mindfulness Informed Psychotherapy is drawn out of the therapists own practice of mindfulness and its literature and teachings. They opine that the direct experience with mindfulness practice is mandatory to understanding the nuances of the tenets of mindfulness.

In working with clients we are of the opinion that integrating the tenets of mindfulness along with the solution focused questions enhance clients understanding of the present moment and clarifies how to build into their ideal future.

Mindfulness Based Psychotherapy

The practice of mindfulness based psychotherapy entails teaching clients mindfulness skills of attention, open monitory and loving-kindness. The specific practices of body scan, awareness of breath, three minute breathing space as well as loving-kindness practices help clients focus attention, and work on self-regulation- a bottom-up approach that leads from learning about one's body, emotions, sensations and thoughts.

In working from the premise of integrating Mindfulness and Solution Focused Brief Therapy we are of the opinion that a Mindfulness Oriented Therapist practices mindfulness himself/herself to enhance their therapeutic presence (attention, self-regulation, compassion and affect tolerance and positive attitudes) that will help facilitate a smoother progression of therapy of any modality. On the other hand, Mindfulness Informed Psychotherapy and Mindfulness Based Psychotherapy can use the solution focused questions as optimal supplements to enhance therapeutic work.

Below is an example of a case of anxiety where Mindfulness Informed Therapy (MIT) and SFBT were integrated (C: Client; T: Therapist):

C: ...I am constantly anxious. I am unable to focus on work and I end up thinking about what might happen if I step out of home, or have to talk to the customer. I am filled with dread and can't seem to take the next step.

T: (MIT/body awareness inquiry): Can you say more about the anxiety? What do you feel in your body when you are experiencing "anxiety"?

C: My heart is racing and I am sweating, I am unable to focus or think straight and there is a pit of discomfort in my stomach. I feel paralyzed and don't want to get out. I am feeling that even now when I talk about it.
T: (MIT/Body awareness inquiry): Can you say more about what it is you sensations you are feeling in your body now?
C: Well...there is discomfort in the pit of my stomach, my toes are turning cold.
T: On a scale of 0 to 10. 0 is the worst your anxiety has been an 10 is the best you have felt where are you on that scale right now?
C: umm 6 or a 7
T: wow that's pretty amazing considering that the dread you feel sounds pretty powerful. How is it at a relatively good number right now?
C: Umm..talking makes me feel better. I also try to take long deep breaths when I am feeling this queasy inside and that seems to help a little bit. When I find myself doing things that, I want to do in spite of the anxiety I tend to feel better.
T: That's wonderful! It appears that you already have a toolbox of resources that help you overcome the queasy feeling. How would you like to build on these tools as you go out into the world after our session?
C: ummm...I would like to try to be at a 6 or a 7 this week
T: Hmm, that's interesting. What might you try to help you get to a 6 or a 7 this week?
C: I am not sure, the breathing helps and so does talking to someone else but perhaps you can teach me a few exercises that can help me?

Here the therapist taught the client three minute breathing space as part of the mindfulness exercise or the Goblet or even the body scan exercise to increase awareness and acceptance of what she is experiencing. From this brief example, it can be seen that the client while anxious she is both able to connect with the moment-to-moment experience of anxiety and also work with a probable future where she can continue to reduce her levels of anxiety through the tools of mindfulness.

Rationale and Means of Integration

Life is about the decisions one make; the wiser the decisions, the lesser consequences. In the process, the first step is to actually realize that one is making choices. Psychological interventions in any form, emphasize on the decisions that one make out of the choices that he/she has. Some habits of ours are so deeply ingrained that many at times we fail to notice our actions, its consequences or spend more than we wanted to. A mindless living stands in the way of experiencing life in its fullest sense.

Mindfulness is both an outcomes and a process, so is solution focused thinking. This article is an attempt to explore the rationale and possibilities of integrating Mindfulness and SFBT in practice. SFBT is a promising intervention helps one build a desirable future, noticing smallest positive changes and constructing solutions. And in the process of solution building, how to be consistent and develop the strength to follow through? Mindfulness based interventions and practices can be of help here. The various mindfulness practices can be used in integration with SFBT techniques, with a premise that mindfulness can enhance the therapeutic milieu and deepen clients resilience to work with challenging situations they confront with and building solutions.

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CLINICAL APPLICATIONS OF EMDR

Bhasi Sukumaran & Deepa Bhatted

What is EMDR?

EMDR refers to Eye Movement Desensitization Reprocessing, a standardized psychotherapeutic approach that was introduced by an article published in the Journal of Traumatic Stress in 1989 by Francine Shapiro (Shapiro, 2014). Twenty years after this publication, Shapiro received the APA Division 56, 2009 Award for Outstanding Contributions to Practice in Trauma Psychology.

How does EMDR work?

EMDR therapy is guided by the Adaptive Information Processing model which upholds the existence of an information processing system that works toward assimilating new experiences with already existing memory networks (Solomon and Shapiro,2008). This innate information processing system integrates new experiences and incoming sensory perceptions are connected to related information that already exists in memory network. This allows us to make sense of our experience, learn what is useful, store it in memory networks with appropriate emotions and use it to guide us in the future. According to this model, chronic dysfunctional perceptions, responses, attitudes, self-concept, and personality traits are all symptoms of unprocessed traumatic memories (Shapiro,2010), This is considered to be the effect of the high level of subjective disturbance experienced at the time of the event, which interferes with the assimilation of these experiences into the normal, comprehensive memory network; resulting in isolated, unprocessed memories that exist in isolation, containing the affects, thoughts, sensations, and behavioral responses that were encoded at the time of the event, which are experienced as intrusive memories. EMDR therapy engages these dysfunctional, unprocessed memories, which may be triggered by the client's current life circumstances, and attempts to convert them into functional ones by using the natural, neural processes of memory consolidation.

What are the steps involved in EMDR?

EMDR therapy follows an 8 step protocol
EMDR 8 Stage Protocol: (Client EMDR handbook)

1. History Taking

This involves taking a comprehensive record of the current symptoms and challenges faced by the client, the situations when they are most problematic, identifying triggering factors if any, experiences during childhood and growing up, as well as the client's future goals and hopes.

2. Preparation

This includes education about trauma and its effects, the AIP model in a manner the client can understand, and the process of therapy. Once the client is educated as to what entails therapy, resource installation is initiated; where the client is taught self-soothing strategies. There are a variety of resources that are commonly used, including creation of a Safe Place, Four Elements Exercise, Container,(Luber,2009) Light Stream exercise and Superhero models . On completion of resource installation, the trauma targets are identified. A list of things that are currently distressing to the client are identified, including traumatic memories, negative thoughts, anxiety/fear, recurrent, distressing dreams in addition to past and current life events that are emotionally painful. A life line chart, highlighting strong positive and negative memories experienced by the client, typically taking 5 or 10 year intervals is helpful in this regard.

3. Assessment

In the assessment phase, the client is guided to choose the target for the therapy session. This is selected from the targets identified in the preparation stage. The client could choose the earliest memory, the most recent event or the most distressing event. The therapist helps in eliciting the vivid image that goes with that memory, generally the worst part of that memory, which recurs whenever that memory is elicited. Then the therapist identifies the negative belief currently held and desired positive belief the client would like to hold instead. In addition the current emotion/s and physical sensations located in the body are identified. The subjective unit of distress (SUD) of the emotions is elicited on a 0-10 scale(higher scores reflecting higher distress) as baseline measure.

4. Reprocessing/ Desensitization

During this phase, the target memory, the image that goes with it, the negative thoughts and emotions, including the physical sensations are reprocessed by the client aided by bilateral stimulation(BLS) provided by the therapist. Traditionally, bilateral stimulation uses eye movement; lateral, side to side movements of the client's eyes while following the therapist's finger or any other object held in the hand, moved from side to side in front of the client's face. However, tapping of the hands alternately or auditory stimulation can also be used. Bilateral stimulation is considered to allow new connections to be made among the memory networks (Shapiro et al, 2007).

At the end of each session of BLS, the client reports any new associations that may have developed. Depending on this, the therapist may either guide the client to further process the new information or go back to the original target memory. The reprocessing is continued over sessions until the target memory ceases to be distressing to the client (when SUD = 0). Strategies like Blocking Beliefs and Cognitive Interweave may be used if the processing is blocked and doesn't proceed to an adaptive outcome, i.e. the negative cognition doesn't change to an adaptive positive cognition.

5. Installation

This phase aims at strengthening the connections of the positive cognition. The therapist checks to see if the original cognition holds good or if the client feels it is necessary to change it to a more appropriate one, which may occur at times. The client is asked to hold the target memory and the positive cognition in mind and further short sets of BLS are given in order to further strengthen the positive cognition. The subjective Validity of Cognition(VOC) is measured on a scale of 1-7(with higher scores indicating higher conviction and validity if the positive cognition)

6. Body Scan

After arriving at a SUD of 0 and a VOC of 7 (in some situations a score of 1 and 6 may be considered ecologically valid), the Body scan is used to identify any remaining disturbing bodily sensations. The client is asked to hold the target memory and the positive cognition in mind and mentally check his or her body from head to toe for any distressing or disturbing body sensations. Any such sensation identified is further processed till it ceases. If the sensation links to a memory, that is further processed till there is no distressing body sensation. Sometimes clients may report positive , pleasurable sensations, which are considered to be linked to the positive cognition, for e.g., feeling light, strong, energized and so on. These are also targeted and processed to further strengthen the positive cognition.

7. Closure

At the end of every session, the therapist ensures that the client is stable and in a state of calmness. If it has been an incomplete session, where the SUD still remains high and the therapist has to end the session due to time constraints, the self-soothing exercises taught in the preparation stage are used to bring the client to a state of equilibrium. The client is reminded to use these resources to deal with any disturbing memories that may arise before the next session.

8. Re-evaluation

Every subsequent session after the initial processing session starts with re-evaluation. The therapist determines how the therapy effects have been upheld over the interim period till the next session. The client is asked if any new insights regarding the problem have emerged. The therapist also checks if any other disturbing memories have been recollected or if there have been any disturbing dreams. The target memory from the previous session is assessed and processed further if required. In brief, steps 4, 5, 6 and 7 are followed when required.

Re-evaluation also examines how the client is currently functioning, how the insights gained in therapy are being integrated in interpersonal interactions. The Future Template is used as role rehearsal for this; wherein the client visualizes future, yet- to- happen scenarios where the appropriate behaviors and responses are utilized. This is referred to as the Three-Pronged Approach, where the Past, Present and Future situations are dealt with in the therapy sessions.

What are the conditions in which EMDR is applicable?

The efficacy of EMDR in the treatment of PTSD is well established. The International Society for Traumatic Stress Studies in 2000 issued Practice Guidelines stating that EMDR is an efficacious treatment for PTSD, while in 2004, EMDR was recommended by the American Psychological Association as an effective treatment for trauma and by the U.S. Department of Veterans Affairs and the Department of Defense as “strongly recommended” for the treatment of trauma (Maxfield, 2009).

Korn(2009) describes a phase oriented EMDR model for the management of complex PTSD, highlighting the role of Resource Development and Installation (RDI) as well as the EMDR treatment goals, procedures, and adaptations for the three treatment phases, viz; stabilization, trauma processing, reconnection/development of self-identity.

Buydens, Wilensky and Hensley(2014) describe the effectiveness of the EMDR protocol for recent events for management of Acute Stress Disorder, in a case series of 7 adults who were treated within a week of the traumatic event, and suggest the EMDR protocol for recent traumatic events is an effective means of providing early treatment to victims of trauma, thereby preventing more severe symptoms of PTSD.

In a review of literature by Wood and Ricketts (2013) on EMDR in the treatment of depression, they found that EMDR reduces comorbid depression significantly along with PTSD symptoms. However, studies on EMDR with clients having a primary diagnosis of depression were lacking, and although case reports in peer reviewed journals suggest that adding EMDR to standard treatment would be useful, the authors conclude that though EMDR has the potential to treat cases of primary depression, it cannot be termed as an evidence-based treatment for depression.

A review on the application of EMDR with specific phobias shows that EMDR can produce significant improvements within a limited number of sessions. (De Jongh, Ten Brocke and Renssen, 1999). In a report of three case studies of specific phobias (De Jongh and Ten Brocke, 2007), different strategies for identifying the memories that could have led the development of specific phobias are discussed. It is suggested that specific phobias that are based on traumatic incidents and phobias with high initial levels of anxiety respond most favorably to EMDR while non-traumatic phobias and those in which a reduction of anxiety has been achieved after treatment would benefit from gradual in vivo exposure.

Brown and Shapiro (2005) report a case study of treatment of Borderline Personality Disorder with co-morbid major depressive disorder (severe anxiety). The client was seen for 20 sessions of EMDR over the course of 6 months. The treatment targets addressed problematic relationships in the client's life, including parents' marital relationship, relationship with each parent, relationships with siblings, relationship with spouse and other important early relationships. The client was able to overcome feelings of insecurity (I am not safe), negative self-concept (I am not good enough), (I am bad) and the relationship with the spouse also improved. The client developed awareness of her strengths and was not easily influenced by others. She was able to deal with her emotions better and gave up self-destructive behavior patterns. The authors are of the opinion that this case provides preliminary evidence for use of EMDR in the treatment of BPD.

Posmontier, Dovydiatis and Lipman (2010) in a case study of a survivor of sexual violence report that EMDR offers a brief intervention that can result in healing in as few as four sessions.

A review of the efficacy of therapies for Obsessive Compulsive Disorder (Ponniah, Magiati and Hollon, 2013) tentatively concludes that EMDR is possibly efficacious for OCD. The need for further rigorous studies in this area is emphasized.

Brown, Goldrick and Buchanan(1997) and Sukumaran (2015) report treatment of cases with Body Dysmorphic Disorder using EMDR. Schneider et al (2007) report management of phantom limb pain in a 38 year old adult 3 years after the loss of the limb.

A review of studies using EMDR with traumatized children (Fleming.J, 2012), found EMDR to be more effective compared to CBT in Type I traumas (single episode traumas), while there is a lack of controlled studies on Type II traumas (ongoing multiple episodes) in children as well as in adults with Type II trauma in childhood, to draw conclusions in this regard. The need for further controlled studies in this regard is emphasized. Bhatted and Sukumaran (2015) discuss a case of prolonged childhood abuse in an adult presenting with dysthymic features who responded favorably to EMDR therapy. A case study on the successful treatment of separation anxiety following the divorce of parents, in a 10 year old boy, using EMDR therapy has been reported (Morrissey, 2013).

The Standards of Practice Committee (SPC) of the American Academy of Sleep Medicine (AASM) recommend EMDR for the treatment of nightmares (Aurora et al, 2010).

Miller (2010) describes an adaptation of the EMDR approach, called the Impulse Control Disorder protocol and elaborates on the Feeling State theory to explain impulse control disorders like sexual addiction, pathological gambling and compulsive shopping. A case study of pathological gambling is also discussed to illustrate the application of the Impulse Control Disorder protocol.

Van den Berg et al(2013) describe the Two Method Approach of EMDR conceptualization and reprocessing of psychosis related memories and discuss 7 cases to demonstrate applications of the different methods of this approach. The obstacles in treatment and strategies to overcome these are also described as well as preliminary guidelines for case conceptualization using this approach.

The above is a selective sampling of available literature to show the extent of clinical applications of EMDR

How does EMDR work?

Theoretical Considerations

Even though the precise mechanisms of change that occur during EMDR therapy are yet to be identified, studies show that the eye movements utilized in EMDR are correlated with a desensitization effect, an increase in parasympathetic activity, and a decrease in psychophysiological arousal (Solomon and Shapiro,2008). The Adaptive Information Processing model holds that, other than symptoms caused by organic deficits, toxicity, or injury, the primary basis of mental health disorders are unprocessed memories of earlier life experiences. The high level of arousal caused by distressing life events disrupts the information processing system and causes these memories to be stored with the original emotions, physical sensations, and beliefs that occurred then(Shapiro 2010). Reprocessing of these memories using the standard EMDR protocol helps to bring about adaptive resolution and improve functioning. It is hypothesized that processing the targeted memories transfers them from implicit and episodic memory systems to explicit and semantic memory systems (Shapiro, 2014). This enables the client to deal with these memories in an adaptive manner and appropriately respond to current life experiences.

The early conceptualization of the mechanism by which EMDR works has been described by Stickgold (2002). He proposes that the repetitive redirecting of attention by using bilateral stimulation (visual, auditory, or tactile) in EMDR induces a neurobiological state which is similar to that of REM sleep. This REM-like state permits the integration of traumatic memories into associative cortical networks without interference from hippocampally mediated episodic recall. This supports the cortical integration of traumatic memories into general semantic networks. Once successfully integrated, corticohippocampal circuits induce the weakening of the traumatic episodic memory and its associated affect. This means that the client is able to see the significance and meaning of the event in terms of their overall life, and thereby to "come to terms" with the traumatic event

Lipke (2000) proposes a four-activity model (FAM) to explain how EMDR works He describes four activities, namely; 1. Accessing existing information 2. Introducing new information, 3. Facilitating information processing, and 4. Inhibiting accessing of information, which encompass the therapeutic activity of all methods of treatment; this four-activity model (FAM) is a useful guide for organizing thinking about therapeutic interventions. He holds that these four categories are seen in EMDR therapy activity, the EMDR stages of History taking, Preparation and Assessment correspond to the first activity of Assessing existing information, EMDR stages of Reprocessing, Installation and Body scan correspond to the second and third activities of introducing new information

and facilitating information processing, and the EMDR phase of Closure for incomplete session corresponds to inhibiting assessing of information.

Kaye(2007) poposes a 2 stage model to explain the effectiveness of EMDR therapy. The model assumes that during EMDR there are two routes of influence that stimulate the anterior cingulate cortex(ACC) to reverse the direction of its reciprocal suppression of cognitive and semantic processing. The error monitoring from the eye-finger-tracking task is considered as first routes. This results in activation of the upper ACC which may reciprocally suppress the affective processing in the lower ACC and improve parallel processing of perspectives back in the upper ACC. The second route of influence could be dopaminergic VTA projections to the ACC that are activated by resource installation, placebo, and novelty effects. These two routes of influence are theorized to comprise the first stage of the proposed two-stage model. The author proposes that novelty-driven OR's may be more prevalent during a second stage. This second stage in the model involves novelty-evoked investigatory orienting reflexes (OR's) from the patient's own newly emerging contextual information. This model considers trade-offs that need to be balanced between gains in desired reflex phenomena versus distraction in working memory and inhibition of implicit memory.

Coubard(2016) uses the Threshold Interval Modulation with Early Release-Rate of rIse Deviation with Early Release (TIMER-RIDER)–model, to explain how attentional control and bilateral stimulation contibutes to EMDR effects. He postulates that two processes acting in parallel: (i) activity level enhancement of attentional control component; and (ii) bilateral stimulation in any sensorimotor modality, leads to lower inhibition which in turn allows dysfunctional information to be processed and thus reduce anxiety.

Psychophysiological Measures

Sack, Lempa and Lamprecht (2007)-investigated stress related psychophysiological reactions,mainly HR-heart rate and HRV-heart rate variability in 16 clients with Type I trauma. They found that PTSD symptoms decreased following EMDR treatment. They also found that stress-related HR reactions significantly reduced, while HRV, indicating parasympathetic tone, increased in the sample following EMDR treatment.

Similarly, Frustaci et al (2010) also report 4 cases of female clients with persistent PTSD symptoms following small 't'.Following EMDR treatment, symptom scores decreased while several HRV measures changed favourably

Both the authors conclude that successful EMDR treatment may be associated with reduced psychophysiological stress reactions and heightened parasympathetic tone.

Oh and Choi (2007) report changes in the resting regional cerebral blood flow in two patients with posttraumatic stress disorder in comparison with 10 non-PTSD participants as control group. They found that cerebral perfusion increased in bilateral dorsolateral prefrontal cortex and decreased in the temporal association cortex. The changes appeared mainly in the limbic area and the prefrontal cortex. They also found that the differences between participants and normal controls also decreased. They conclude that EMDR reverses the functional imbalance between the limbic area and the prefrontal cortex

In a study on "PTSD-model" subjects who were basically healthy with unpleasant autobiographical memories (traumatic life events like death of a family member, unfaithful partner, accident to a family member) using near-infrared spectroscopy (NIRS), (a non-invasive optical technique for monitoring cerebral haemodynamic changes), Amano and Toichi (2016) found changes in [oxy-Hb] in the superior temporal sulcus (STS) and orbitofrontal cortex (OFC). During a vital therapeutic stage, a significant reduction in the activation by forced eye movements was observed in the right STS, and a trend toward a reduction in the left OFC. The authors are of the opinion that the hyperactivation of the right STS observed on the recall of unpleasant memories, and its subsequent normalisation by eye movements, reflects an important neural mechanism of the psychotherapy which possibly involves brain regions related to memory representation and emotion, and also those that link memory and emotion, like the amygdala. Similar results were reported by Rimini et al (2016), who also reported that eye movements were correlated with a reduced oxy-Hb concentration, which they considered to be linked to a reduced working activity of the prefrontal cortex.

Herkt et al(2014)demonstrated the first time evidence for a putative neurobiological basis of the bilateral alternating stimulation as used in the EMDR method. They investigated 22 healthy female university students (mean 23.5 years) who were scanned with fMRI while confronted with blocks of disgusting and neutral picture stimuli. They found that when bilateral alternating auditory stimulation was given along with the presentation of pictures, there was a specific increase in activation of the right amygdala while the left dorsolateral prefrontal cortex showed the opposite effect with decreased activation. They conclude that the increase in limbic processing along with decreased frontal activation is in line with theoretical models of how bilateral alternating stimulation helps in therapeutic reintegration of information during EMDR.

A review of 20 years of studies on the neurobiological mechanism of EMDR (Bergman,2010) summarizes the following:
The neuroimaging post-EMDR findings have been noted with respect to left frontal lobe activation, decreased occipital activation, and decreased temporal lobe activation. These findings are indicative of the following: (a) emotional regulation due to increased activity of the prefrontal lobe, (b) inhibition of limbic over-stimulation by increased regulation of the association cortex, (c) reduction in the intrusion and over-consolidation of traumatic episodic memory due to the reduction of temporal lobe activity, (d) the reduction of occipitally mediated flashbacks, and (e) the induction of a functional balance between the limbic and prefrontal areas.

Recent findings suggest bilateral dorsolateral prefrontal activation as well as left orbitofrontal and right ventromedial prefrontal activation The implications of these findings have yet to be fully understood, but suggest repair in memorial function, working memory/concentration, and affect regulation, respectively. Increased thalamic activation following successful EMDR treatment suggests the repair of failures in cognitive, memorial, affective, somatosensory, and interhemispheric integration, which are disrupted in PTSD.

Psychophysiological studiesshow findings of parasympathetic relaxation responses, increased HRV parasympathetic tone, reduced electrodermal function, reduced EEG P3a function, and increased vagal parasympathetic functions which suggest that EMDR mediates directly on affect regulatory systems. It probably induces an initial “compelling” parasympathetic state change that facilitates information processing and neural linkage repair thus leading to the eventual stable trait change that is seen as a result of successful EMDR treatment.

An overview of the clinical applications of EMDR is attempted in this article. The review is by no means exhaustive, rather, a sampling of research findings have been collated with a view of addressing commonly asked questions regarding EMDR therapy, it’s effectiveness and mechanisms of change. The authors are of the view that EMDR is a rewarding therapeutic approach, with wide applications among the clinical population. There is a dearth of published Indian studies and it is hoped that this modest overview will stimulate further research and practice in EMDR.

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APPROACH TO A CHILD WITH BEHAVIOUR PROBLEM

P. Krishnakumar

When a child presents with abnormal behaviour or behaviour problem, the first step is to decide whether the behaviour is truly abnormal or problematic. Parent's perception of abnormal behaviour may not always be true. The line separating "normal" and "abnormal" is very thin. Parenting skills and family factors greatly influence the behaviour of the child. If the behaviour is causing problems in the family or at school, there is need for intervention. The next step is to decide whether the behaviour is appropriate to the age of the child. Behaviour which is normal in a 4 year old child may be abnormal in a10 year old child. ABC (A- what causes the behaviour; B-What is the behaviour; C- What are the consequences of the behaviour) will help to decide the nature of the behaviour problem and plan management.

There are two approaches to behaviour problems in a child. Dimensional approach, where one concentrates on individual behaviours and categorical approach where one considers diagnostic categories. Delinquent behaviour, aggressive behaviour, inattentive behaviour, hyperactive behaviour, impulsive behaviour etc are problem behaviours. Behaviour syndromes are categorised depending upon the confluence of behaviours. Thus, attention deficit hyperactivity disorder (ADHD), autism spectrum disorder (ASD), oppositional defiant disorder, conduct disorder (CD) etc are behaviour disorders. Even though categorised based on the manifested behaviour there are definite biological correlates to behaviour disorders and ADHD and ASD are neurodevelopmental disorders where the developing brain is affected.

So the next question is whether the behaviour fit into any known behaviour syndromes. We will see the clinical characteristics of some of the common behaviour disorders.

Attention Deficit Hyperactivity Disorder (ADHD)

Attention Deficit Hyperactivity Disorder (ADHD) is the most common child psychiatric disorder with a prevalence rate of 5-10% among school aged children. The three cardinal clinical features of ADHD are hyperactivity, impulsivity and inattention. There are three sub-types of ADHD - Predominantly hyperactive - impulsive type, predominantly inattentive type and the combined type. In majority of children all the three features are present. Children with hyperactivity present early during the preschool period itself whereas children with predominantly inattention present when attention problems affect academic functioning and hence usually during the primary school or secondary school age. As the age advances hyperactivity comes down and attention problems become more predominant.

There are no diagnostic tests for ADHD and the diagnosis is made based on clinical criteria. According to DSM 5, to make a diagnosis of ADHD, the symptoms should be present for more than six months duration and should be present in more than one setting. (eg. school and home). The symptoms must begin before the age of 12 years and should not be secondary to other medical or psychological disorders. The symptoms should cause impairment in social, academic or occupational functioning. Co-morbid psychiatric disorders like oppositional defiant disorder, conduct disorder, learning disorder, anxiety disorders and depression are common in children with ADHD. Tics disorder and seizure disorder may coexist.

Genetic factors, perinatal brain insult, environmental toxins, endocrine abnormalities and structural brain defects are implicated in the aetiology of ADHD. Thyroid hormone disorders and heavy metal poisoning like lead poisoning can lead to symptoms of ADHD and should be ruled out. Micronutrient deficiencies like iron deficiency, zinc deficiency may be associated with ADHD and should be treated. Food colouring agents and preservatives are reported to cause ADHD symptoms and should be looked for while treating children with ADHD.

Abnormalities in the level of various neurotransmitters like dopamine, nor-epinephrine and epinephrine in the CNS are associated with ADHD. Drugs effective for ADHD act through modifying the functioning of neural circuits involving these neurotransmitters.

The treatment of ADHD includes psychosocial interventions and pharmacotherapy. Pharmacotherapy should be combined with psychosocial interventions. Drugs used to control the symptoms of ADHD are usually divided into two groups - Stimulant drugs and the non- stimulant drugs. Stimulant drugs include methylphenidate, dextroamphitamine

and their combinations. The non stimulants include atomoxetin, clonidine, and risperidone. For optimum results, pharmacotherapy should be combined with psychosocial interventions. Treatment of ADHD is not just prescribing drugs. Academic and school problems and problems in the family environment can precipitate and exacerbate the behaviour problems in a child with ADHD. These issues should be addressed along with pharmacotherapy. Counselling regarding the importance of balanced diet, avoiding junk foods and food preservatives should be part of the treatment program. Correction of iron deficiency, zinc deficiency and other micronutrient deficiencies will go a long way in improving the behaviour and attention span. Advice regarding life style modification should be given. The importance of rest, play, TV time, and adequate sleep should be discussed with parents and children.

Autism Spectrum Disorder (ASD)

Autism Spectrum Disorder (ASD) is characterised by impairment in reciprocal social communication, impairment in social interaction and restricted repetitive and stereotyped patterns of behaviour. The onset of the problem is during the early developmental period.

Impairment in social interaction is manifested as impairment in the use of non-verbal behaviours (such as eye to eye contact, facial expressions, body postures and gestures) and failure to develop age appropriate peer relationships, inability to share enjoyment, interest or achievements with others and lack of social or emotional reciprocity. Impairment in communication is manifested as delay or total lack of development of spoken language, impairment in the ability to initiate and sustain conversation, stereotyped or repetitive use of language. There could be stereotyped and repetitive motor mannerisms like body twisting, hand or finger flapping or twisting, inflexible adherence to routines or rituals. There may be associated features like abnormal fears and phobias, hyperactivity, eating and sleep problems, temper tantrums, aggressive behaviour, self injurious behaviour like wrist biting. Seizures occur in about 25% of children. Though children with autism can have normal or above normal intelligence, majority of them have varying degrees of intellectual disability.

Asperger's syndrome is a type of high functioning autism characterised by impairment in social interaction and repetitive, restricted and stereotyped behaviour with no delay in language development and no cognitive impairment.

The usual clinical presentation is in the toddler period with history of language delay. The parents may complain of odd behaviour. Motor milestones may be normal or delayed. It is important to look for hearing impairment in any child presenting with

speech delay. Observe the child for any impairment in reciprocal social interaction. Most often behaviour observation for sufficient time will help to reach the diagnosis.

ASD may be the result of varying aetiologies causing insult to the developing brain. There is no laboratory diagnosis and no characteristic EEG or MRI findings. Since the aetiology varies, the clinical presentation also varies. It is in this context that the concept of autism spectrum disorder is relevant. The spectrum concept refers to children with mild autistic features at one end and with severe autistic features at the other end. Early detection and sensorimotor stimulation and initiation of remedial therapy will help a lot to overcome the disability. Parents should spend quality time with the child and promote reciprocal social interaction. Early initiation of preprimary schooling with special attention to the child will help in places where specialised therapy services are not available.

Disruptive, impulse control and conduct disorders

Disruptive, impulse control and conduct disorders include behaviour disorders characterised by problems in the self control of emotions and behaviour. These problems usually violates the rights of others and bring the individual into conflict with law or social norms or authority. The behaviour disorders in this group include oppositional defiant disorder,conduct disorder and intermittent explosive disorder. These disorders usually have onset during childhood or adolescence.

Oppositional Defiant Disorder (ODD)

ODD is characterised by irritable or angry mood, argumentative or defiant behaviour and vindictive nature. The problem is more common in boys and begin in the preadolescent age group. Child with ODD is most often angry or irritable. He often looses temper and is often touchy and easily annoyed. Arguments with authority figures or other children is common and refuses to comply with rules and regulations. He may blame others for his mistakes or misbehaviour. Vindictive nature may be present. The behaviour problem is usually present in one situation only. The usual clinical presentation is with history of behaviour problems at home while at school the child is well behaved. The problem is usually with adults or peers whom the child knows well. Sibling rivalry may be present. ODD may be associated with ADHD. Anxiety disorders and depression may coexist. ODD may precede childhood onset type of conduct disorder or ODD may be milder type of conduct disorder.

Conduct Disorder (CD)

Conduct disorder is characterised by aggression to people and animals, destruction of property, deceitfulness or theft and serious violation of rules. Tendency towards aggression to people and animals result in behaviours like bullying or threatening others, initiating physical fights with others, using weapons to harm others, forced sexual activity and cruelty to animals. Tendency to destroy property is manifested as deliberate fire setting with the intention of causing damage and deliberate destroying property belonging to others. Deceitfulness or theft includes lying and stealing, cheating others like "con man". Children with CD may present with history of behaviours like truancy (deliberately staying away from school and wandering outside), running away from home or staying away from home without parental consent. Various types of delinquent behaviour or substance abuse may be associated with CD.

There are three subtypes of conduct disorder, based on the age of onset of the symptoms- Childhood onset type, adolescent onset type and unspecified onset type. In the childhood onset type the onset of symptoms is before 10 years while in the adolescent onset type there are no conduct symptoms before the age of 10 years. The childhood onset conduct disorder usually present with problems in peer relation ship at school. There may be preceding features of ODD and associated ADHD. The problems can be mild moderate or severe. Some children with CD have guilt or remorse over the behaviour, but others have no such prosocial feelings. There may be socialising type and non socialising type of children with CD. The prognosis is better in adolescent onset conduct disorder with most of them recovering before adulthood. The childhood onset type of CD is more serious and there is chance of developing antisocial personality or continuing problems into adult age. Treatment consists of behaviour intervention and counselling. Drugs may help to regulate mood or control behaviour.

Concept of Comorbidity

Several disorders may coexist in a child. A child with ASD may have features of ADHD like hyperactivity, impulsivity and inattention. A child with CD or ODD may have associated ADHD. Depressive disorders and anxiety disorders may be associated with many behaviour disorders. Scholastic backwardness and specific learning disorders may be the cause of many behaviour issues and may also occur secondary to behaviour disorders. One should look for co-morbid disorders and these should be considered while planning management strategies.

Similarly physical problems like anaemia and micronutrient deficiency may contribute to behaviour problems in children. Behaviour problems are more in children with chronic physical illnesses like bronchial asthma and epilepsy. Dietary intervention and life style modification will be essential component of management of behaviour disorders in children and adolescents.

Recent behaviour change in a child

Onset of the behaviour disorder will help to reach a diagnosis. In neurodevelopmental disorders the symptoms will be present for long duration from early developmental period itself. Any child with acute behaviour change needs detailed evaluation to rule out organic causes. Neurodegenerative disorders may present initially with change in behaviour. Behaviour change may be the early feature of neurological disorders like ADEM or auto immune encephalopathies or ICSOL. Episodic abnormal behaviour may be manifestation of seizure disorder. Once organic causes are ruled out look for any stress full life events.Behaviour change may be manifestations of anxiety disorders depressive disorders or adjustment disorders.

Child with a behaviour problem: Points to consider

- Is the behaviour really abnormal?
- Is the behaviour appropriate to the age of the child?
- What are the situational factors?
- Does it fit into known behaviour syndromes?
- Is there any underlying emotional disorder?
- What are the family factors involved?
- Is there any associated physical problems?

Child with acute behaviour change

- Rule out organic causes
- Look for stressful life events
- Look for emotional disorders like anxiety or depression

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CHAPTER III

"ANOTHER WAY" TO IMPROVE UPON: USE OF SOLUTION FOCUSED BRIEF THERAPY IN IMPROVING FUNCTIONALITY IN PERSON WITH SCHIZOPHRENIA- A CASE STUDY.

Sreekanth.T & Ijas Abdul Majeed

Introduction

Solution focused Brief Therapy is a future focused goal directed approach to brief therapy developed initially by Insoo Kim Berg, Steve de Shazer and their colleagues at the Milwaukee Brief Family Therapy Center in 1982. It is an approach to psychotherapy based on solution building rather than problem solving. It explores current resources and future hopes rather than the present problems, past causes and typically involves only three to five sessions. Solutions focused therapists viewed clients as an expert on their life and more importantly, what will be useful to them. SFBT can thus be defined as a client centered and collaborative process. It proposes that the development of a solution is not necessarily related to the problem. Solution Focused approaches and active Solution Focused Therapy can be used with severe mental illness and long term disability (O'Connell, B. (2005)

This is a particular advantage because most other therapies are not considered appropriate in such circumstances. Severe mental illness often requires the use of hospital care and medication in combination with psychological approaches. The management of both acute and long term disorders can be enhanced by the use of solution focused conversation and approaches.

This is the case of a patient presenting with 16 years duration of severe mental illness (paranoid Schizophrenia) relapsed due to poor drug compliance since 6 months, admitted in National Institute of Mental Health and Neurosciences, Bangalore for treatment with the application of SFBT to improve the functionality.

Solution focused conversations and techniques used, including scaling question, coping questions, exception questions and miracle questions. Pre and post changes assessed

with Solution Focused inventory (SFI) and improvement in functionality assessed on the basis of Indian Disability Evaluation and Assessment Scale (IDEAS). Patient's self-care, interpersonal activities and motivate some of the motivation statements made by the patient in the session are *"at least I'm able to get hospitalized, able to talk to people and at least I manage to do my self-care twice in a week", "I would be able to go out to buy coffee, and I would be smiling and maintaining a conversation with my uncle and mother", "I would be would be going to a relative's house and attending functions"*

In the day to day activities has been improved after the 9 sessions of Solution Focused Therapy. The patient got discharged after two months of admission and the session continued on out-patient basis, currently patient is working in a private company.

Brief clinical history

Ms. A, 36 years old, female, unmarried, currently not working, hailing from middle class social economic status from rural Karnataka. She is presented with 16 years duration of illness characterized by auditory hallucination, delusion of persecution, and delusion of control with significant social- occupational dysfunction with preserved cognitive functions and partial insight. Clinical diagnosis of Paranoid Schizophrenia was made.

According to International Classification of Disorders (ICD 10) the schizophrenia disorders are characterized in general by fundamental and characteristic distortions of thinking and perception, and by inappropriate or blunted affect. Clear consciousness and intellectual capacities are usually preserved, although certain cognitive deficiency may evolve in the course of time. Pharmacological treatment has been started initially and symptoms were starting to become under control. However, the patient remained impaired in day to day functioning. During the time of admission patient's personal hygiene was very poor up to the extend she hasn't had bathed for 4-5 months, communications were very minimal, wouldn't interact or would not go out for past 6 months and her functioning was completely impaired.

Rationale of solution focused breif therapy

Therapist used Solution Focused Brief Therapy (SFBT) to motivate and improve the functionality of the patient. Session initially started with building rapport with the patient and the patient was also allowed to describe about her problem, in the initial phase of the sessions. The session continued by asking her about the "best hope" from

the therapy. Once she adequately described about the concerns, the therapist started exploring her preferred future by focusing on solution focused conversation.

SESSION 1

The patient was referred to therapist for improving her activity of daily living and functioning by the treating team.

Session initially started with building rapport with the patient and the patient was also allowed to describe about her problem, in the initial phase of the sessions. The session continued by asking her about the "best hope" from the therapy. According to patient she would be at least able to go out and sit outside for sometimes without any disturbance and after that at least taking care of the hygiene.
Once she adequately described about the concerns, the therapist started exploring her preferred future by focusing on solution focused conversation.

SESSION 2

In the second session therapist asked the patient that "if she was managing her illness better, what difference would have been there in her life" as a medium to understand her preferred future with more clarity. The patient's response to that was a surprise (which she expressed later) and started thinking about that for a while. She replied that, she would be working in a company, would be doing all the activities at home independently, attending family and social functions, going for shopping, would be happy and altogether I would be more functional.

Patient added that in her 12 year duration of the illness and hospitalizations this is the first time someone asked this questions rather asking about her illness, conditions and medications.

Session progress as follows

Therapist: on a scale of 0 to 10, 10 being you're very much functional and 0 being not at all functional, where would you like to mark yourself now.
Patient: Hmmm.,.I would see myself at three
Therapist: Hmmm...great, what made you to say that you're at 3?
Patient: Ahhh... at least I'm able to get hospitalized, able to talk to people and at least I manage to do my self-care twice in a week.
Therapist: wow... that's surprising to know that you're at 3 but not anything less than that.
Patient: (Smiled)
Therapist: on a same scale in the near future where would you like to be?

Patient: (thinking) yeah, I feel I must be at 8.
Therapist: oh..That sounds great. What differences would be there if you are at 8 and how do you know that you are at 8?
Patient: maybe I will be able to do all the activities independently such as going to shop, cooking.
Therapist: What else would make you say that you're at 8?
Patient: (thinking) I would be helping my mother in the kitchen, reading books, spend time with relatives and start taking tuition classes for the kids as a mean of small income.
Therapist: I'm really glad to hear from you that, while you are staying here in the hospital and till I meet you in next time after a week, on the same scale where would you like to be?
Patient: (Thinking) I would like to be at four
Therapist: What small things, which would you like to take up in order to slightly move forward to four on the scale.
Patient: If I was at four I would be able to go out to buy coffee, and I would be smiling and maintaining a conversation with my uncle and mother".
Therapist: That's great. I hope those changes would happen to you.

SESSION: 3

In the third session onwards patient is motivated for the session and started taking initiative for improving some of the area of the functionality and become more hopeful in the session. Scaling question is used to motivate the patient as well as to set out the centering for the therapy process.

Therapist: Hi, What is better today? And what is your best hope from today's session?
Patient: ahhh..Was looking forward for the session and yesterday I went to buy coffee for mom and myself.
Therapist: oh that's really great.
Client: thank you, I went here only in the hospital premises for buying coffee.
Therapist: well done, how did you manage that?
Patient: mmm... every day my mommy gets to purchase coffee for me, I thought I can get today.
Therapist: What did you feel after doing that?
Patient: I felt happy that after a long time I'm going out of the room.
Therapist: what else?
Patient: I felt more energetic.

Therapist: that's good. Now If you are slightly moving on the scale where you desire to be?
Patient: ah... I want to be in 5 on the scale.
Therapist: What differences would be there if you're at 5?
Patient: "I want to be going out without much disturbance of noises (she was referring to auditory hallucination), I would be buying small provisions for the day to day uses, so that my momma can be rested, I would be straining to sit out in the hospital garden, also I would be capable to take little bit which I wasn't doing past one year".
Therapist: ohhh..That's really wonderful. How will you groom to reach those ends?
Patient: I would be sitting with my mother in the garden.
Therapist: What else?
Patient: I will ask my uncle to get one book for me to read.
Therapist: right..we will keep these things are our next goals and we have to work on that.
Patient: Ok.

SESSION :4

The client set out to get more industrious in the session and started thinking about a solution rather than problems which circulated here. Facilitating to find the solution for the problems and difficulties in the therapy process were becoming easier. One more important modification was the client's attitude towards the therapy and changes happened to her, the client started perceiving the changes that also facilitated to further improve the motivation.

Therapist: Hi, (patient was noted to be very much happy in the session)
Patient: Hi, my mom is happy today.
Therapist: What did you manage to get her happy?
Patient: today I sat outside in the garden with my mom.
Therapist: wow, it might be really difficult for you to execute that in spite of suffering some difficulties.
Patient: Yes, but now I feel glad about what I managed.
Therapist: it's wonderful news, ok. What else is better? Imagine, if you slightly want to proceed forward on this scale where you would wish to be?
Patient: ahh.. I would be in 6.
Therapist: What differences would be there if you're at 6?
Patient: I would be would be belonging to a relative's house and going to social occasions.
Therapist: What else would be different from now?

Patient: I would be moving in a public transport because I find it very difficult to travel on buses because of the noises, so that I feel that these noises are controlling me.
Therapist: What else you would be doing in order to be at 6 on the scale?
Patient: I planned to increase the walking time and time which I spend for reading, I think I can make it more than 45 minutes per day.
Therapist: that's a good, very good step from your side; I trust I will find some more positive word when we meet next time

SESSION: 5

The session started with a question from the client about new dress which purchased on the previous day. The client started not just recover the answer but also operating more on the result with less importance with the troubles.

Therapist: what is better today? (Observed that the patient has changed her usual attire and found to be more serious in her personal hygiene)
Patient: I went to my uncle's home on the last day and spend time over there.
Therapist: that's nice, what else did you get along?
Patient: I was less angry with mom, last time I was engaged in the bus to my uncle's place so I was angry with mom. Only yesterday I haven't felt angry at all, rather I enjoyed.
Therapist: oh..So, I hope you would visit an uncle's house more often.
Patient: yes, I will try.
Therapist: That is great news for me.
Patient: Thank you (smiled)
Therapist: I am eager to know where do you stand on the scale of 1 to 10 at present.
Patient: I call back, I must say I am at 6 as I am doing regular walk, reading my books and last weekend I have belonged to my uncle's house and spend my time over in that respect.
Therapist: Suppose you're making a slight move in the scale where you would like to be?
Patient: I will be in 7 on that scale.
Therapist: oh good. What differences would have to be there if you move to 7 on the scale
Patient: I would consider bringing together for computer sessions here in psychiatric rehabilitation center, in fact my doctor was asking to practice that long back, I feel this is the time to answer that.
Therapist: what else you would be performing in order to say that you are at 7?

Patient: I also will be increasing the walking time and sitting outside the garden and spending more time reading scripts.

Therapist: that's really amazing surely I will ask your doctor to refer you to the computer section. What is the best hope after discharging from the hospital?

Patient: of course I have to be regular to all my activities.

Therapist: what else you would be doing at home?

Patient: I have to prepare a resume, maybe I can advertize about the tuition class.

Therapist: Wow, that's really great.

Patient: Thank you.

Therapist: that's a good Decision. (The plan was to continue therapy after discharge on OP basis.)

Patient: thank you

Therapist: All the best.

[Patient got discharged with all these plans.]

SESSION :6

(Outpatient Department)

Therapist: Hi A, How are you?

Patient: I'm fine.

Therapist: what is better now?

Patient: I attended three interviews in last two weeks; I also set up my resume to. I was planning to start tuition, but then I thought why I can't, I try for better jobs.

Therapist: That's really amazing. What else did you do there?

Patient: I have prepared my resume and after that searched in the newspaper about the job vacancies and applied there.

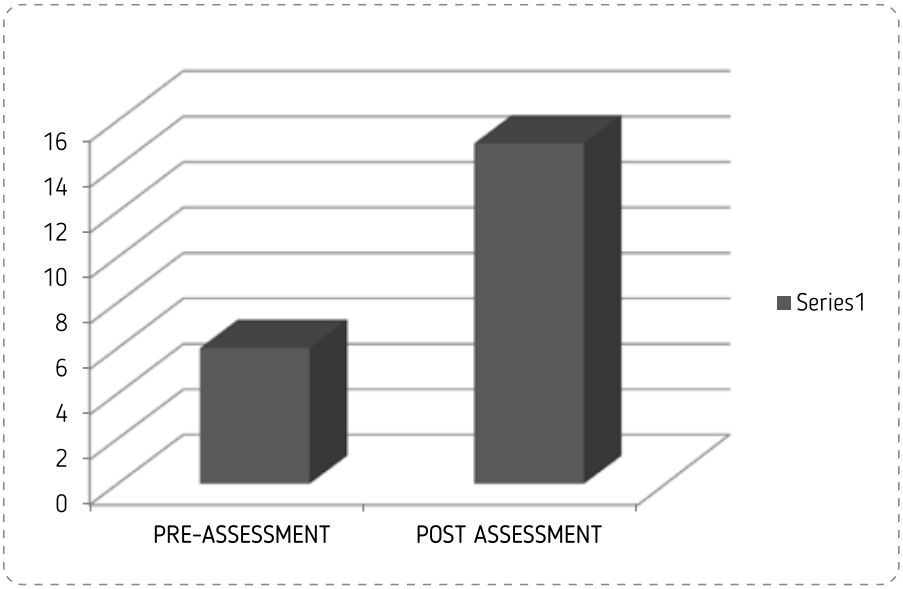
Therapist: oh... I'm happy for you, hope you will be employed next time.

Currently Ms. A is working in a private company.

Outcome of intervention

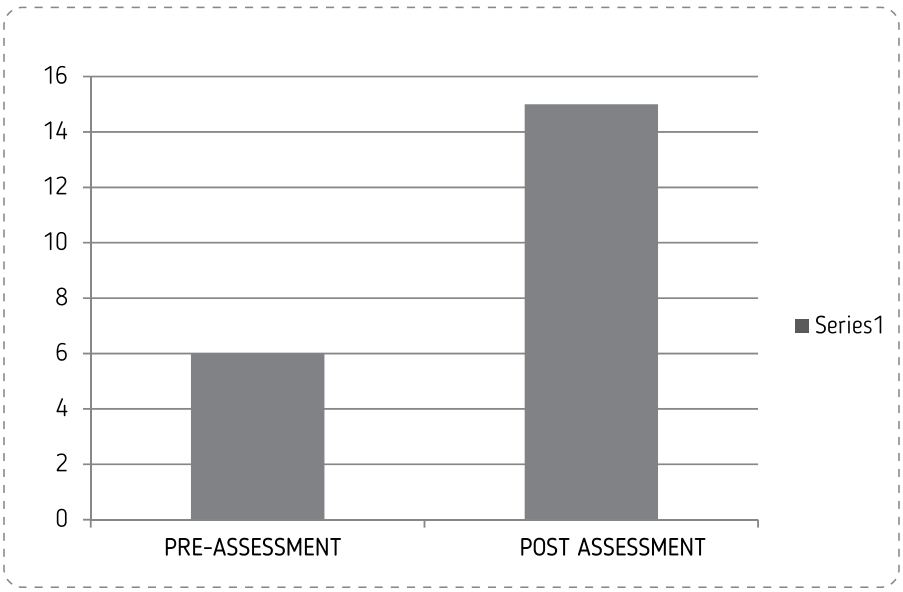
The outcome of the sessions has been assessed by Solution focused inventory (SFI) (Grant, A. M, 2012) and Indian disability Assessment and Evaluation Scale (IDEAS), (Mohan, I., Tandon, et.al 2005)at pre and post intervention.

SOLUTION FOCUSED INVENTORY



Pre and post assessment has been administrated with solution focused inventory, which is self administrated 13 item likert scale with 0-5 scoring pattern. The results shows that the attitude towards the problem and finding solution for that has been changed after the session. Few important changes would be spending time to for thinking about the problem rather than finding a solution and working, more focus on problem rather than changes, imagine the goals then working towards them and keeping track of the progress and changes has been tremendously changed after the session. Infact as we know most of the therapists, clinicians and families tend to focus more on the problem along with patient rather than finding or searching for the solution and working on that, perhaps imagining a solution itself is great difficult for most of the people who is having problem. Through the brief sessions changes could bring in the attitude and motivations of the patient.

IDEAS



Functionality of the client assessed with indian disability evaluation and assessment scale, which has four main domines including self-care, interpersonal activities, communicationa and interaction and work along with total duration of the illness. At the time of admission in the hospital and few days followed to that self- care, interpersonal activities, communication and interaction and occupational functioning has been severly affected and patients socio occupational functionality were impaired. Post assessment results shows that the socio occupational functioninhg has been improved tremendously.

Discussion

There is a conscious effort in solution-focused brief therapy to stay focused on solution dialogues and to deemphasize problem dialogues. Such a conscious effort grows out of a concern about the role of language in creating or sustaining reality.

Solution-focused brief therapy views language as the medium through which personal meaning and understanding are expressed and socially constructed in conversation (de Shazer, 1991, 1994). Furthermore, the meaning of things is contingent on the contexts and the language within which issues are described, categorized, and constructed by clients (Wittgenstein, 1958). Wittgenstein (1958) suggested that the way an individual experiences the reality is framed and limited by the language available to him or her to

describe it. As such, these meanings are inherently unstable and shifting (Wittgenstein, 1958).

In this case one of the important elements is the role of language. At one point of time when the therapist asked "if you did not have this problem what you would be doing" the immediate reply given by the patient is in her 15 years of history of various treatments first time someone is asking about this way rather focusing on the problems and the difficulties. Most of the therapies are directive approach where the therapist directs a person to the activities or therapist define the destinations. Solution-focused brief therapy believes that solutions to problems are not objective "realities" but rather individually constructed. Clients are the most legitimate "knower" of their life experiences and should be the center of the change process. Externally imposed therapeutic goals, as promoted by therapy approaches or society, may be inappropriate or irrelevant to the needs of clients. In increase, clients generally are willing to work harder if they set the goal of therapy and perceived the goal as personally meaningful.

The techniques like 'scaling' would always give a steering for the therapy and also adjust the goals to work and assess the improvement of the client. Coping questions always help the client understand the internal force to surmount the difficulty which he/she was practicing earlier.

The long term functional disorders like schizophrenia, it is important to improve the functionality of the individual who is suffering with the unwellness. The pharmacological treatments can control the symptoms, but along with other psychosocial interventions application of solution focused interventions and solution focused languages will be beneficial to improve the functionality so by motivating the person and helping the individual to find his achievable tasks and ultimately assist the person to avail them.

Conclusion

When we discuss about the application of solution focused therapy with a person with psychotic illness, there are various apprehensions might come to every newborn practitioner. The primary concern is about the cognitive functions of the person with psychotic illness and the interference of the symptoms, use of language and how much the person can think to set a solution for his problems. One of the major ambiguities is about using of westernized solution focused techniques like "miracle question" and framing of the nomenclature in other speeches.

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SOLUTION-FOCUSED BRIEF THERAPY IN INDIAN CONTEXT: A REVIEW

Sheby Babu, Fincy M P & Baijesh A.R.

Abstract

Solution- Focused Brief Therapy (SFBT) involves a future-focused, goal-directed approach that highlights the importance of searching for and constructing solutions rather than focusing on problems. This paper is an attempt to review the published research works using SFBT from the Indian context. Since, SFBT is an emerging field of psychological intervention in India, there are only limited number of SF studies carried out in the subcontinent. Articles on SFBT in peer reviewed journals available online published between 2005- 2015 were considered for review. The search lead to identifying three research papers meeting the criteria for the review. An attempt is made to critically review the articles and major observations are highlighted. The review concludes SFBT as a promising approach and suggests a preliminary efficacy while the critique highlights the need for for methodologically strong further research in the area for more conclusive evidence of applied SFBT.

Key words: Solution Focused brief therapy, depression, anxiety

Introduction

Solution Focused Brief Therapy (SFBT) is an approach to psychotherapy based on solution-building rather than problem-solving. Solution-focused therapy is a strengths-based approach, emphasizing the resources people invariably possess and how these can be applied to the change process. It evolved out of the clinical practice of Steve de Shazer, Insoo Kim Berg, and colleagues at the Brief Family Therapy Center in Milwaukee, Wisconsin, in the early 1980s (de Shazer, 1982, 1985, 1988; de Shazer, Berg, Lipchik, et al., 1986). The main therapeutic task is searching and constructing solutions, helping

the client to imagine how he or she would like things to be different and what it will take to make that happen. Not much attention is paid to the diagnosis, history taking, or exploration of the problems. SFP assume that the clients have the capacity to envision change, are doing their best to make the change happen and the solution, or at least part of it, is probably already happening (WeinerDavis, de Shazer, & Gingerich, 1987). Treatment is brief, usually lasting less than six sessions.

SFBT explores current resources and future hopes rather than present problems and past causes. It has great value as a preliminary as well as sufficient intervention. SFBT has grown from a little-known and unconventional therapeutic approach to one that is now widely used in many countries. It is used in family service and mental health settings, in public social services and child welfare, in prisons and residential treatment centers, in schools and hospitals (Miller, Hubble, & Duncan, 1996). Reports of practitioners suggests successful outcomes and high client satisfaction while using SFBT.

In the Indian subcontinent, practice and research on solution focused practices (SFP) are in its infancy. SFBT follows a systematic, focused process that relies on assessment, client engagement, and implementation of change strategies in client behavior within a relatively short period. SFBT is relevant in the Indian context also due to socio-economic and policy related reasons. India is a country with a population of 1.25 billion, of which more than 20% of people falling below poverty line with no medical insurance coverage in place for treatment of mental illness. Above all, availability of less than 1 licenced clinical psychologists per 1 million population (as per Central Rehabilitation Registry, Rehabilitation Council of India, 2015), shows the dearth and increased responsibility of professionals. The need for using less time consuming and effective alternatives becomes relevant in this pretext. From the available studies done in India, it can be understand that, brief therapeutic models have a significant role in the Indian clinical scenario as we have limited resources to meet high demand.

This article is an attempt to review the published research works in SFBT from the Indian context. A comprehensive review is planned with the available research to see to what extent there is empirical support for the effectiveness of SFBT in India. Based on the review, the article further discuss the extent to which SFBT has received empirical support and conclude with recommendations for the kind of additional research that is needed to establish SFBT clearly as an empirically supported treatment.

Method & Review

The review was limited to articles on SFBT appeared in peer reviewed journals published between years 2005 and 2015 and available online. The search using search engines Google and Yahoo lead to identifying three research papers meeting the above mentioned criteria for the review. An attempt is made to describe and critically review the articles.

Table 1: Showing the details of the article reviewed

	Reddy, D.P., Thirumoorthy, A., Vijayalakshmi, P., & Hamza,A.M.(2016)	Baijesh, A. R. (2015)	Jaseem Koorankot, Tilottama Mukherjee & Z. A. A. Ashraf (2014)
Setting	Not mentioned	General Hospital Out Patient department	Primary health center and Community health center
Sample size	1	15	9
Problem	Moderate levels of depression	Social anxiety disorder	Depression with tribal Community
Selection criteria		Who met ICD-10 criteria for social phobia on the basis of standard -structured clinical interview.	Who met ICD-10 criteria for mild, moderate, or severe depressive episodes; recurrent depressive episodes; or adjustment disorder with brief depressive reaction
Demographics	1 female of age 19 year, Studying at 10th standard	15 adolescents Average age:15.67 60% female	9 participant (66% female) from tribal community No formal education Belongs to low socio economic Status Aged between 24-48
No. of sessions	6	12 (including intake and assessment sessions)	5
Modality	Individual	Individual	Individual

Therapist's experience	Not mentioned	Clinical psychologist Trained in SFBT	Clinical psychologist Trained in SFBT
Monitored	Yes	Yes	Yes
Design	A-B outcome design	A single group pre- post intervention design	A single group pre-post test design
Measures used	HAM-D Self rating scale of 0-10	The Liebowitz Social Anxiety Scale for Children and Adolescents (LSAS-CA), Hamilton Anxiety Rating Scale (HAM-A), The General Self Efficacy Scale (GSE).	Beck depression inventory-II
Follow up	None	Mentioned as a pilot study	For those who required

Effectiveness of SFBT on Depression

Reddy et. al,(2016) evaluated the effectiveness of SFBT on moderate depression. Ms. S, 19 year old female failed in SSLC presented with pervasive sad mood, decreased interest in studies, poor academic performance, irritable over trivial issues, anger outbursts, crying spells, guilt feelings, feeling of worthlessness, disturbed sleep, reduced appetite, difficulty in attention and concentration. The therapist followed single subject research design A - B outcome design with baseline and treatment phase to test the treatment gains. Participant presented the compliance of inability to remember studied portions, poor academic performance, anger out bursts, dull and lethargic, pressure from mother in studies, low appetite, decreased sleep and low self-esteem. Participant was attending Bharatanatyam classes and meditation classes before the onset and she discontinued those due to academic pressure. The case worker established a good rapport with the client and worked on the anxieties and worries of her. They together identified 3 goals: (1) Managing academic stress, (2) Enhancing attention and concentration, and (3) Planned

preparation for exams. The client reported Bharatanatyam, practices , western dance and going for evening walk with friends as the source of coping with stressors from her early experience. So, case worker identified these activities as the solution for her problem and instructed to continue the same. The intervention consisted of 6 sessions. Baseline data was collected from the participant using the Hamilton Depression Rating Scale (HAM-D). The client had scored 21 on HAM – D baseline. Post-intervention, on HAM-D the client scored 6. Also the client reported significant improvement in the scaling responses indicating a positive change in the client's experience.

The therapist used the strength of client to construct a good solution to get out from her problem and the therapist was able to examine the improvement of the client in each and every phase. The therapy resulted in attaining the goal and improving her academic performance. The article does not contain any clue on the treatment protocol followed. Adding on to the limitations, the therapist's experience and training in delivering SFBT is not mentioned, the narration of the case process was abstruse and lacunae in the explanations given stands out.

Koorankot, Mukherjee and Ashraf (2014) studied the outcome of SFBT in the context of a tribal community in India, to get some insights about the applicability of solution-focused practice in Indian community mental health settings. The population consists of tribal people of Wayanad district in Kerala, who were diagnosed by a consultant psychiatrist and clinical psychologist as having mild, moderate, or severe depressive episodes; recurrent depressive episodes; or adjustment disorder with brief depressive reaction according to the International Classification of Diseases-10 (ICD-10) criteria. Clients with co-morbid psychiatric conditions or chronic physical illness were excluded from the study. The sample size was 11 initially, but 2 participants were dropped out and thus the sample size became 9. The sample consisted of 6 females and 3 males. Most of the participants presented complaints of low mood; lack of interest, especially in work; irritability; difficulties to sleep; and crying spells. Treatment was provided by a team consisting of psychiatrist, a clinical psychologist, a psychiatric social worker, a psychiatric nurse, and a pharmacist. The treatment followed the specifications of European Brief Therapy Association's treatment manual for SFBT along with medication. The treatment consisted of 5 sessions, 45-60 minute long one session per week in the beginning and later reduced to one session per two week. Follow-up sessions were continued for those who required it with no further measures obtained. As a solution for the problem, the goals were set like "go for work in the morning". Most of the participant's goals for the therapy were focused on work, sleep, and healthy interaction with others. A single group pre-post test design was used to examine the outcome of SFBT. The pre-test data were collected from the participant using the Beck Depression Inventory-II (BDI-II). After the

initial evaluation, psycho education was provided regarding participant's conditions, it's treatment, medication and it's side effects. A post-test was done two weeks from the fifth session by using BDI-II. Upon close observation of the domains of BDI-II, it was noted that participants showed improvement in domains of affect, work, and satisfaction. The pre-test, post-test scores were analyzed by using Wilcoxon T statistics. Results indicated a significant difference in the BDI-II scores at pre- to post- treatment. The authors conclude that SFBT is a useful therapeutic approach, which can be applied to Indian tribal populations in treating depressive disorders. An informal survey also was made after the therapeutic sessions by asking each participant what they thought was the most beneficial aspect of the sessions and most of them reported about the relief they get after talking out their problems to someone who understood them and they felt that somebody was there to listen to them.

This study employed a well-defined inclusion criteria while recruiting the subjects, used a treatment protocol, and used standardized outcome measures. The study took an effort to explain the opposite result of one participant in terms of influence of external factors. It also point out some extra points like change in attitude of family members and increase in support, increase in the interaction of the participant with family, society and community. These findings can be considered as an effort to understand the effectiveness of SFBT in terms of the quality of life of the participants. As the sample size is too small the result cannot be generalized to the entire population. But being a pilot study, it was done well and it opens the door for new findings in deep study by limiting its drawbacks. The researchers have mentioned the limitations from their perspectives such as, the lack of a controlled condition and difficulty in separating the effects of the two treatments (SSRI & SFBT). The researcher has proposed a plan for the upcoming main study by setting with four groups in which two are experimental and another two are control to identify the influence of external factors, selection and measurements by two clinical psychologists other than the therapist who administers SFBT to prevent the therapeutic relationship influence on result. The researchers had conducted the current study very well within the available time frame. Since this was a pilot study, considering its limitations and drawbacks, the main study is expected to be done in a more systematic manner.

Effectiveness of SFBT on Social Anxiety Disorder (SAD)

Baijesh (2015) examined SFBT treatment program for adolescents with SAD. The fulfillment of selection criteria were examined on the basis of a standard structured clinical interview, done it in the outpatient department of a hospital. The population was adolescents and adolescents with a history of substance dependence within the past 6 months; mental retardation; pervasive developmental disorder; organic mental disorder; acute suicide potential; or previous participation in behavioral or CBT for SAD were excluded from the study. The sample consisted of 15 adolescents pursuing their higher secondary education with an average age of 15.67, who met ICD-10 criteria for social phobia (generalized). The study employed with a single group pre-post intervention design. Treatment Manual for Working with Individuals 2nd Version (Solution Focused Brief Therapy Association, 2013) was used in the current study. SFBT was given in 12 sessions to all participants spread over 3 months time based on the Solution Focused Therapy. Some of the major active ingredients which include in SFBT are: (a) developing a cooperative therapeutic alliance with the client; (b) creating a solution versus a problem focus; (c) the setting of measurable attainable goals; (d) focusing on the future through future- oriented questions and discussions; (e) scaling the ongoing attainment of the goals to get the client's evaluation of the progress made; and (f) focusing the conversation on exceptions to the client's problems, especially those exceptions related to what they want different, and encouraging them to do more of what they did to make the exceptions happen. Participants found the treatment to be highly acceptable, and they also reported decreases in avoidance compared to fear in social situations. All the participants except two, by the end of treatment had no clinically significant Social Anxiety. The pre-test and post-test scores were obtained from The Liebowitz Social Anxiety Scale for Children and Adolescents (LSAS-CA), Hamilton Anxiety Rating Scale (HAM-A), The General Self Efficacy Scale (GSE). Paired samples t tests were used to examine pre- to post treatment changes on LSAS- CA, HAM- A and GSE ratings. The result found significance on: HAM-A with t value 10.68($p < .01$); LSAS-CA Fear and Avoidance subscale with t value 13.39($p < .01$) and 35.05($p < .01$) respectively; and also significant on GSE with t value11.06 ($p < .01$). This implies the improvement of participant from social anxiety symptoms, self efficacy, and anxiety. From the findings it is concluded that patients decreased their use of avoidance-based coping after undergoing the treatment.

The use of a pre-post design, treatment manual, and standardized outcome measures suggests that subjects were benefited from the SFBT intervention. Researcher pointed out some potential limitations of the study in terms of generalizability and lack of controlled conditions. The review was limited due to very less number of (or no) studies done in the area of SFBT for SAD. The treatment administered was 12 sessions spread

over three months, but the researchers has not given details of each sessions, the rationale for providing 12 sessions while usually SFBT has a relatively less number of sessions. The researcher also had failed to mention how all the participants took the same number of sessions. It was mentioned that the 12 sessions were inclusive of the intake and assessments, but no information was provided on the number of sessions taken for all. A non parametric equivalent of t test such as Wilcoxon signed rank test would have been more appropriate measure to be used. Although subjects appeared to benefit from the intervention, it cannot be determined that the benefit was due specifically to the SFBT intervention as opposed to the nonspecific effects that presumably accompany any intervention. Since it is a pilot study, the researcher can improve his study by resolving all these limitations.

Conclusions

This article is aimed at reviewing the SFBT in the Indian context. 3 studies were considered for the review. Out of the three studies, one was a case report, and other two were pilot studies. Though the outcome result of all the three studies suggest SFBT has a preliminary efficacy in the treatment for depression and SAD, it is premature to conclude so. Studies that are well designed, methodologically sound, with controlled and comparison conditions and adequate outcome measures are are needed to draw conclusive evidence in terms of efficacy and effectiveness. The wide variety of settings and populations studied and the multiplicity of modalities suggest SFBT as a promising therapeutic tool with a broad range of applications in Indian context. Several investigators seemed to acknowledge as much by characterizing their research as ''pilot studies'' or ''preliminary investigations.'' Clearly, the studies reviewed here are moving in the direction of efficacy research. These studies provide a foundation for conducting more rigorously controlled investigations that can provide more conclusive evidence of SFBT outcome.

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HOW DOES THE MIRACLE QUESTION WORK ITS MIRACLE?

Kavitha Sebastian & Waheeda Matheen

The miracle question is an important feature of solution focused practice. The miracle question is a question posed to the client quite early in the session. It is posed in the following manner:

"Suppose, tonight when you are asleep, a miracle happens, the miracle being that the problem that brought you here is gone, it no longer exists. And because you are sleeping you are not aware that a miracle has happened. What would be the first signs that you would notice tomorrow morning when you wake up, that would tell you that a miracle has happened?"

This question is put to the client very slowly and carefully, with frequent pauses for the client to properly grasp the meaning of the question. The question is best asked dramatically.

Insoo Kim Berg and Peter De Jong(2002) contend that the miracle question is the most useful for at least a couple of reasons. According to Berg, it gives the client permission to think about an unlimited range of possibilities. Secondly, the question has a future focus. It evokes a picture of a time when in their lives when their problems are no longer problems. It begins to move the focus away from current and past problems and toward a more satisfying life.

Once the question has been asked, the therapist helps the client in arriving at an answer to the question. Sometimes, clients need a little encouragement to attempt to answer the question, as it is a strange and unexpected question.

Many practitioners agree that the miracle question is one of the most formidable tools in the arsenal of psychotherapeutic techniques. They also agree that its application is very simple, though not easy .So, how does the miracle question actually work its magic? It is evident that both psychological as well as physiological processes play a role in enabling the effective use of the miracle question.

It has been observed time and again that individuals who experience psychological distress due to various problems tend to dwell on these very same problems. Studies have documented that mulling over and ruminating on negative events tends to further exacerbate the circumstances, by drawing the person into a depressive mood.

As a result of this process, clients who come for therapy often have a lot to say when it comes to talking about their problems. However, when asked about how their life would be without the problem, they are often at a loss. They may need encouragement from the therapist to describe such a situation and what would be different about their lives once the problem disappears.

Therefore, the client is urged to describe positive, concrete changes which are observable that will enable him to accomplish his goals. As a natural consequence, the client begins to talk about positive changes that will empower him rather than talk about negative aspects that are disabling him. This shifting of gears creates a new dynamic for further exploration of desired change.

All human behavior is goal directed, whether we are conscious of the goal or not. What the miracle question accomplishes is to arrive at the most salient and meaningful goals of the client. That is why, the miracle question is akin to an easy back door entry into a heavily fortified fortress. Many therapists agree that more often than not, the presenting problem is not the actual problem of the client. Occasionally, it may be because the client is confused. However, mostly, it is a deliberate ploy to avoid confronting the real cause of anxiety. Working through the defense mechanisms of the client is long and hard work. The miracle question allows us easy access to the most important and meaningful aspects of the client goals, without having to work through the usual resistance.

Yet another way, in which the miracle question is useful, is the way in which it puts things in perspective. Very often, clients realize that their situation is reasonably close to the normalcy that they seek. Frequently enough, clients come to understand that they are very much on track to reach their desired goals and that what they are facing is really a minor setback.

Finally the miracle question effectively demonstrates to the client, the great degree of control she has over her own behavior. By describing how the problem ceases to be a problem and in what manner it would enable her to behave in a way that she desires, it seeks to put the onus on the client for the desired change, in a collaborative fashion. Therefore, this question devises a way to bring home the point that individuals are responsible for their own behavior.

An emotion is a complex, multi-component episode that creates a readiness to act (Atkinson & Hilgard, 2003). Its components include cognitive appraisal, subjective experience, internal bodily changes, facial expressions and thought-action tendencies.

Many studies have shown that negative emotions like anger and sadness etc invoke negative thoughts and memories. They spark strong urges to act in specific ways; to fight when angry, to flee when afraid and so on. On the other hand, positive emotions broaden our thinking and actions. Joy urges us to play, curiosity creates the urge to explore and so on. While answering the miracle question, there is a shifting of gears from problem-talk to solution-talk. The topic of the conversation veers to client strengths and positive, enabling choices that free the client from the shackles of problem trance. As the client continues to talk about positive change and his own strengths in making it happen, there is a corresponding change in emotion.

According to Dolan,R.J(2002), the importance of emotion to the variety of human experience is evident from the fact that we remember and notice what evokes our emotions like anger, happiness, sadness etc. Events that do not evoke emotions are seen as mundane and we forget it over due course of time. Dolan (2002) emphasizes that emotion exerts a powerful influence on reason and contributes to the fixation of belief.

Therefore, a change in emotion facilitates the process of change by providing the motivational force.

Conclusions

A complex interplay of a variety of factors contributes to make the miracle question a highly effective technique in psychotherapy. The miracle question plays a pivotal role in solution-focused practice.

Psychological factors like beginning to talk about constructive, positive changes lead to a corresponding change in emotions, which, in turn, act as a motivational force that impels the client towards positive change. The momentum provided by a combination of the above factors, when used skillfully by the therapist leads to desired change.

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INTEGRATING VIRTUAL REALITY AND SOLUTION-FOCUSED BRIEF THERAPY: AN EXPLORATION

Mageshprasath Nagarajan

Abstract

Virtual reality and solution focused brief therapy (SFBT) have been used in the field of psychotherapy and counseling for more than twenty years now. Virtual reality exposure therapy is currently used to treat a variety of disorders such as anxiety, several phobias, posttraumatic stress disorder to name a few. Likewise, SFBT is also generally used to treat social phobias and other behavior disorders, especially in children like stuttering, bullying, etc.

There is an increase in both virtual reality exposure therapy and SFBT to treat behavioural disorders. Solution focused brief therapy was developed by Steven de Shazer and Insoo Kim Berg at the Milwaukee Brief Family Therapy Center in Milwaukee, Wisconsin. The main principles of this therapy are to treat clients as they are capable of bringing out change in their lives by setting goals for themselves and to focus on the solution to a problem and not the problem itself. In the meantime, virtual reality exposure therapy – along with cognitive behavior therapy – revolves around the principle of exposing clients to anxiety-provoking situations, which are built based on the specified problem of clients, and slowly increasing the exposure thereby making them immune to that particular stimulus.

Although it is around for many years, Virtual reality exposure therapy has been criticized for the lack of therapeutic alliance during therapy. Meanwhile, SFBT also faces criticism for not looking into the emotions of clients such as sadness, grief, anxiety, etc. This concept paper is about discussing the avenues of virtual reality therapy combined with solution focused therapy. This is an effort to use the advantages of both the therapies – the exposure of anxiety-provoking situations to clients and also the therapeutic relationship between the client and therapist. With the advent of new technologies in virtual reality, it is possible for the therapist to dive into the client's world and explore the emotions, feelings and thoughts, thereby setting up new goals and achieving them.

Keywords: Exposure Therapy, Mental Disorders,Solution-focused Brief Therapy, Therapeutic relationship, Virtual Reality.

Background

Personalized therapy has been influenced by the introduction of technology in the field of medical science and recent breakthroughs in research have made it possible to detect the early onset of life-threatening diseases (Personalized Medicine Coalition, 2014). Also, sophistications and technological advancements have made it possible to make medical services to even the remote places on earth. Likewise, in the field of applied health care, especially in counseling and psychotherapy, using technology therapists and counselors are able to reach many people, who do not have access to such services. Today, using telehealth technologies people get access to counseling services from their remote locations, which have internet connection, such as a health clinic in a village or a person's home(Luiselli & Fischer, 2016). Apart from these technologies one that is prominently used, which is one of the topic of interests of this paper, is virtual reality therapy (VRT).

Virtual reality therapy has been used for past twenty years to treat patients with anxiety disorders, post-traumatic stress disorder, to name a few, as an alternative to or combined with invivo exposure therapy and imaginal therapy(Meyerbröker & Emmelkamp, 2010). Virtual reality therapy deals with creating a three-dimensional environment on a computer in which the person can move through and interact. It is an immersive experience, wherein the clients are put into an environment relevant to them and making them interact with it(Klinger, Bouchard, Legeron, Roy, Laurer, Chemin, Nugues, 2005; Segal, Bhatia, & Drapeau, 2011). For instance in the randomized-controlled trial conducted by Miloff et al., one group of participants was given invivo exposure to specific phobia to spiders and the other group was given VR exposure therapy. The results of this study suggested that the effectiveness of both the therapies were same. Although there were some problems with this trial, like only one session of therapy was conducted, this is an example of the efficacy of VR exposure therapy(Miloff et al., 2016).There are numerous advantages of using VR therapy. Some of them are having control over the stimuli, feeling of embarrassment is less as public exposure is avoided and more importantly, increase in the efficacy of the treatment by reducing the sessions.There were many inhibitions for therapists to use VR in their therapeutic practice, one of which is the VR machine itself the technicality in handling those machines(Segal et al., 2011). Today, due to advances in science and technology, we have VR devices that can be worn over the head, which match the same kind of experience as those machines. These are called Head Mounted Displays and some of the leading technology companies

have also launched their consumer products such as Microsoft's HoloLens, Facebook's Oculus Rift, etc. These devices can be taken anywhere and developing applications are also simple(Krijn, Emmelkamp, Olafsson, & Biemond, 2004; Miloff et al., 2016). Recently, Disney has released a new virtual reality system that is capable of making you feel rain or a beating heart. Using these newer systems, the application of VR in therapy is endless. The therapist can make the clients feel what they wanted to feel in the real world under a safe climate.

The second topic of interest of this paper is solution-focused brief therapy (SFBT). It was developed by Steve de Shazer and Insoo Kim Berg in the 1980s. It was the product of their work in the Brief Family Therapy Center in Milwaukee, Wisconsin. The main premise of this therapy is to focus on the solution rather than the problem and it is possible for every client to find the solution on their own, the only work of counselors is to make the clients self-aware of their potential. The basic focus is not on the symptom or the problem but on providing a safe climate for clients to create a framework that could be used to achieve the intended goal (Stalker, Levene, & Coady, 1999). Because of this approach it is known to be an goal-oriented approach. The characteristic features of solution-focused brief therapy as stated by Steve de Shazer and Insoo Kim Berg (1997):

1. The therapist asks the "Miracle Question" at some point in the initial interview session
2. The therapist asks the client to rate something on a scale of 0 to 10 in all interview sessions
3. The therapist takes a break during the interview
4. After the break the therapist summarizes about the session and compliments the client, while diiscussing the goals or tasks to be done before the next session.

This therapy is one of the most famous and widely used psychotherapy in the world. It is due to the fact that the power of change is at the hands of the client and is hugely influenced by the strengths and virtues of the client, and previous solutions or exceptions. Research in SFBT has been underway since the early age of it as de Shazer had interest in research. This has led to defining SFBT, introducing guidelines and protocols in conducting a session, and suggesting process of change (Trepper, Dolan, McCollum, & Nelson, 2006).

Both VRT and SFBT have been a part of behavioral therapy. While it is evident that VRT is used as an alternative to imaginal or invivo exposure therapy, Bannik (2007) suggested that SFBT can be looked as a form of cognitive behavioral therapy. As in the problem-focused behaviour therapy, SFBT also uses the same learning principles, the

only exception being in SFBT the analsyes are made of using exceptions and not by the automatic thoughts or behavior(Bannink, 2007). Stemming from this belief, it is not unusual to integrate VRT and SFBT to provide a more personalised therapy to the clients and also decreasing the number of sessions.

Integrating Virtual-reality and Solution-focused Brief Therapies

In their attempt to applying SFBT to career counseling, Burwell and Chen (2006) has reviewed the basic principles of SFBT. The main focus of the paper is to not impose VRT on to SFBT, but to include the advantages of virtual reality in treating the clients with SFBT. This is possible by identifying the areas in which VR can be useful and how to use it effectively.

Miracle question

One of the important aspects of SFBT is to make the clients feel positive about their future, while acknowledging the present moment. The miracle question used by the therapist brings out a positive orientation to the clients, when they feel that there is possibility for them to be different and change. Change, here, is positive and is considered to be inevitable(Burwell & Chen, 2006). The miracle question is used in order for the clients to effectively identify a goal. Using VR in this process can increase the efficacy of the goals formed by the clients, also increasing their self-confidence. The clients can experience how people would react knowing that they have changed. Instead of just imagining what would be different, the clients can first-hand experience the change that they have been working for.

Forming a working alliance

The working alliance is the foundation of SFBT. When de Shazer was conducting his research in the 1980s, the research question was “What do clients and therapists do together that is useful?”(de Shazer & Berg, 1997). The whole therapy is based on the positive rapport that is being build in the initial minutes of the first session. This is usually done by demystifying the counseling process and asking what are the expectations of the clients. The research into therapeutic alliance of VRT is scarce as the role of therapist is usually not significant in it (Burwell & Chen, 2006). As both VRT and SFBT are used as separate treatment methods for clients with social anxiety, the use of SFBT with VRT in treating those clients can increase the efficacy of both the therapies significantly. For example, with a client with fear of public speaking it will be easier to build the trust with a few sessions of SFBT and then using VRT to reach the goal or tasks without facing much embarassment to the client.

Identifying exceptions

In SFBT, exceptions play a major role in setting up the goal or identifying the strengths of the clients. In order to find the exceptions, therapists ask clients about the circumstances during which the particular problem does not occur or occur infrequently or occur less(Burwell & Chen, 2006). Identifying exceptions can lead to developing scenarios in virtual reality in which the clients will feel safe. Knowing their exceptions will help to reframe the clients thought process and thereby bringing out confidence in achieving the goals set during the sessions. For a phobic client, this can be used to recognize the lowest level of stimuli and then increase it from there.

Briefer therapy

Solution-focused therapy itself is a brief therapy and VRT has also shown some significant efficacy as a brief therapy, the success of which can be attributed to the technology that brings you closer to your controlled-phobic environment thereby making a behavioral change quicker than ever(Miloff et al., 2016; Segal et al., 2011). As discussed earlier, by including VRT in some attributes of SFBT and vice versa it is possible to make the number of therapy sessions lesser. While using VRT it is possible to record the behavior during a session, to review a session and, for the therapist, to identify the areas that needs improvement.

Summary

Both VRT and SFBT have been around, for treating clients, for many years, separately. The idea of this paper is neither to impose VRT on to SFBT nor SFBT on VRT, but it is to include the advantages that the each therapy possess and provide a briefer and better experience to clients. There are challenges in using VRT, such as cost of the headset and making scenarios; training therapists; ethical and legal concerns to use newer technology for therapeutic purposes; side effects of using VR; and finally the clients have to be open to newer therapeutic models(Segal et al., 2011).

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DISPOSITIONAL MINDFULNESS AND SOLUTION FOCUSED THINKING AMONG UNIVERSITY STUDENTS

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Students are very likely to encounter various stressors such as adapting to a new environment, balancing their workload, making new friends, becoming more independent, developmental transitions during the college years. Kabat-Zinn (1994) defined mindfulness as the awareness that emerges through paying attention on purpose, in the present moment, and non-judgmentally to the unfolding of experience moment by moment. Every person has unique ways of approaching a problem. Some focus on the problem or the reason why a problem emerged (problem focused thinking) whereas others prefer to think about possible solutions that help them to solve a problem (solution focused thinking). The present study aims to find the relationship between dispositional mindfulness and solution focused thinking among university students. The sample consist of 60 University students of age between 18 to 25. The tools used for the study were Mindfulness Attentional Awareness Scale (Brown & Ryan, 2003) and Solution Focused Inventory (Grant, 2006). The results suggest that there is a positive relationship (r= 0.50) between solution focused thinking and dispositional mindfulness indicating further need for exploration and applied level implications.

Keywords: Solution- Focused Thinking, Dispositional Mindfulness, University Students

Introduction

Mindfulness is part of what makes us human, the capacity to be fully conscious and aware. “Mindfulness,” as used in ancient texts, is an English translation of the Pali word, sati, which connotes awareness, attention, and remembering. (Pali is the language in which the teachings of the Buddha were originally recorded. The first dictionary translation of sati into “mindfulness” dates to 1921 (Davids & Stede, 2001). It helps us to recognize when we also need to cultivate other mental qualities–such as alertness, concentration, loving kindness, and effort–to skillfully alleviate suffering. Jon Kabat-Zinn, the foremost pioneer in the therapeutic application of mindfulness, defines it as “the awareness that emerges through paying attention on purpose, in the present moment,

and non-judgmentally to the unfolding of experience moment to moment" (Kabat-Zinn, 2003,) Mindfulness means paying attention in a particular way: on purpose, in the present moment, and non-judgmentally (Kabat-Zinn, 1994).

Mindfulness alone is not sufficient to attain happiness, but it provides a solid foundation for the other necessary factors (Rapgay & Brystrisky, 2007). Mindfulness is being awake to the present moment and choosing where to put our attention, noticing when we have got caught up in our mind's story of how it is, is mindfulness. (Dunkley & Stanton, 2014). Mindfulness puts a person in the driver's seat so that the person is in control of one's own mind, rather than the mind being in control of the person (Linehan, 1993). In defining mindfulness, Linehan breaks it down into what we need to do to be mindful (i.e. observe, describe, participate) and how we need to do it(i.e. one thing in the moment, non-judgmentally, effectively).

The term disposition is often used interchangeably with the terms trait and personality to reflect stable and enduring characteristics (Allport, 1961), Personality theory is likely to provide a useful framework for understanding individual differences in mindful behaviors and experiences. An examination of Dispositional Mindfulness in relation to well-established models of personality, such as the Five Factor Model (FFM; McCrae & Costa,2003), could provide important descriptive and predictive information about the nature of dispositional mindfulness. Distinctions have been made between different types of mindfulness, referred to here as dispositional (i.e., trait) and cultivated (i.e., trained, practiced), and researchers are beginning to identify characteristics unique to each. Operational definitions have been proposed and used to guide research, leading to more precise theoretical models, and there are now both theoretical and empirical reasons to believe that Dispositional Mindfulness is a two dimensional construct reflecting both the focus and quality of attention. Researchers are encouraged to capitalize on the growing evidence base and approach Dispositional Mindfulness as a unique individual difference factor strongly rooted in developmental, cognitive, and personality disciplines. Distinguishing between Dispositional Mindfulness and related constructs can inform theories specific to Dispositional Mindfulness, as well as theories related to mindfulness and self-regulation more broadly. Whether Dispositional Mindfulness is best considered a basic tendency or a characteristic adaptation (McCrae & Costa, 1999).

Solution Focused Thinking involves evaluating a current problem or situation and determining a reasonable, practical plan to attack that problem or situation. Solution-focused thinking is opposite to problem-focused approaches. A problem-focused approach assumes that by understanding the causal structure of a person's difficulty, effective pathways to action will emerge. In contrast, the solution-focused approach

rejects the exploration of causal aetiology, focusing instead directly on how to create the desired change. Indeed, it holds that a search for causal aetiology may well be pointless, and could even lead to a narrowing of possible actions, eventual undermining of self-efficacy and reductions in motivation and resilience (Cavanagh, 2006; Cavanagh & Grant, 2010; McKergow & Jackson, 2005; McKergow & Stellamans, 2011). Solution focused thinking is emerged from a postmodern, social constructivist approach, solution-focused brief therapy which is concerned with how individuals (or a family) view solutions to problems. This therapeutic method is less interested in why or how a problem arose than in possible solutions (Sharf, 2012).

Solution-focused therapy, which emphasize people's resources and resilience and how these can be used in the pursuit of purposeful, positive change. Solution-focused cognitive processing is characterized by a style of thinking that rejects excessive focus on problems and their causes. It focuses on identifying approach goals and unnoticed resources and finding multiple pathways to achieving those goals. Thus a solution-focused thinking style can be expected to be associated with well-being and positive affect. This is because reflecting on one's goals and thinking about ways to attain those goals tends to stimulate pathways thinking (Snyder, Rand, & Sigmon, 2002) and increases self-efficacy (Bandura,1982), both of which are frequently associated with well-being (Peterson, 2000; Sheldon, Elliot, Kim, & Kasser, 2001; Sheldon, Kasser, Smith, & Share, 2002).

The Present Study- Need and Significance

Students are very likely to encounter various stressors such as adapting to a new environment, balancing their workload, making new friends, becoming more independent, developmental transitions during the college years. Every person has unique ways of addressing and approaching a problem. Some focus on the problem or the reason why a problem emerged (problem focused thinking) whereas others prefer to think about possible solutions that help them to solve a problem (solution focused thinking). For a solution focused thinking, it is assumed that, one needs to be in the 'here and now'. The present study aims to find the relationship between dispositional mindfulness and solution focused thinking among university students. The contextual and constructivist philosophies of the SBFT and Mindfulness allows for the focus to be on the present moment challenges as well as future-oriented solutions that help a person fully access his repertoire of skills. The dearth in the literature relating these two concepts on university students. Hence the present study can provide more light to these aspect and may have implications at different levels.

Methods

Sample and Design

The present study is based on the data obtained from the university students who are studying in Central University of Karnataka. The whole university students are the population and 60 students were selected as sample. The study followed a purposive sampling method.

The present study adopts a correlational design.

Procedure

Students in the Central University of Karnataka were approached to participate in the sresearch. About 60 students were identified who has proficiency in the English language to participate in the study. Student participation in the study was anonymous and by filling out the survey, and informed consent were obtained from the participants to process their data for research purposes. They were also informed that they could terminate participation at any point while filling in the questionnaire. No incentives were provided. Then the researcher provided the tools to the participants. Subject was told briefly about the purpose of the study. The subject was assured about the confidentiality and the demographic details collected from the participant. Two self reported measures were distributed among the participants, namely Mindful Attention Awareness Scale (MAAS) by Brown & Ryan (2003) and Solution-focused Inventory (SFI) by Grant (2011) along with socio-demographic data sheet.

Measures Used

Mindful Attention Awareness Scale (MAAS): MAAS is a 15-item scale developed by Brown & Ryan (2003), designed to assess a core characteristic of mindfulness, namely, a receptive state of mind in which attention, informed by a sensitive awareness of what is occurring in the present, simply observes what is taking place. Internal consistency levels (Cronbach's alphas) generally range from .80 to .90. The MAAS has demonstrated high test-retest reliability, discriminant and convergent validity, known-groups validity, and criterion validity.

Solution-focused Inventory (SFI): SFI, developed by Grant (2011) is a 12 item scale with three subscales: Problem Disengagement, Goal Orientation and Resource Activation. Reverse scoring should be done for the items numbered 1, 2, 4 and 5. Total scores for the SFI are calculated by simply summing all 12 items (after reverse scoring relevant items). The use of a total 12-item SFI composite score and also the use of individual 4

item subscale scores (PD, GO and RA) are supported by the Grant et al (2012) validation study. Test-retest reliability over 16 weeks was 0.84. Cronbach's for the 12-item scale was 0.84.

Results and discussion

Table 1 : Correlation between MAAS and SFI scores

	N	r
MAAS	60	0.503**
SFI		

** p < 0.01 (two-tailed)

As shown in the Table 1, there exist a significant positive correlation solution focused thinking and dispositional mindfulness.

The aim of the present study was to find the relationship between solution focused thinking and dispositional mindfulness. For a solution focused thinking, it is required that, one needs to be in the here and now. It is found that there is positive effects on mindfulness on awareness of present moment (Nicole et.al, 2007). Mindfulness is found to be associated with positive mental health (Moore, Brody, Dierberger, 2009), while Masuda et al., (2010) found that self-concealment positively related to general psychological ill-health and negatively related to mindfulness among college students. In a study by Visser (2012) the solution focusedness of coaches was found to be related to their thriving at work and SF Behavior and SF Mindset were positively correlated with thriving at work. The development of solution focused thinking and mindful attitudes could allow one to focus on the present moment challenges as well as future-oriented solutions and its enhance individual self-acceptance, lead to positive behavioral change, effective self-regulation skills.

Summary & conclusions

The present study concludes that there is a positive relationship between solution focused thinking and dispositional mindfulness. The study has limitations such as non randomized sampling method and small number of sample restricting the generalizability of the finding. The future studies can adopt measures to have a better representative sample while studying. Yet, the finding is suggestive of a significant positive relationship between dispositional mindfulness and solution focused thinking. This has implications

at various levels of applications. Researchers can explore the possibility of further studying whether dispositional mindfulness can predict the solution focused thinking among individuals. If so, developing quality of mindfulness can contribute to solution focused thinking and vice versa. Further the possibility of integrating mindfulness and solution focused at intervention level can be explored as both mindfulness and solution focusedness compliment each other have similar contextual and constructivist philosophical roots.

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WHERE DOES INDIAN SOCIAL WORK STAND IN SCALING QUESTION? AN OVERVIEW ON SFBT TRAINING AND PRACTICE

Nafeesath Sabida S.M & Ijas Abdul Majeed

Abstract

As the future focused, goal directed and solution oriented intervention, SFBT is a promising language for serving people who are looking forward for a change in life. The successful steps reported by the countries like China, Singapore, Taiwan and Nepal are strengthening the promise of effective outcomes of SFBT in Asian countries (1). Hence professional social workers are dealing with psycho-social and economic issues of individuals and families the knowledge, training and evidence based practice of SFBT need to be fortified for delivering quality services. The present study is an attempt to understand the training and practice of SFBT in the area of professional social work in India.

Introduction

Solution focused practice was introduced in India, mainly in therapy setting as many other intervention models. It is been spreading into education, supervision and coaching. Understanding about where the professionals stand in the scale is of high importance for delivering better service to the needy. Here the authors are trying to comprehend about introduction of SFBT took place in Indian social work, as an evolving therapy by focusing it's inclusion in training, practice and research.

SFBT training in Indian Social Work

Knowledge and skills of the therapist need to be progressed when dealing with human life issues. As social work profession is concerned, it is of high importance because it deals with the psycho-social and economic issues of persons. Every individual is unique, so their nature of difficulties is also different from one another, so as the solutions to be focused on during therapy. Because of which in-depth training in SFBT is of high relevance.

Being the only professional body of solution focused practitioners of India, ASFP-I (Association of Solution Focused Practices - India) have contributed it's organized efforts in the form of workshops. Up to 25 workshops have organized across India under the banner of ASFP-I, executed by Mr. Jaseem Koorankot, the pioneer Indian practitioner of SFBT, which served its purpose with active participation of professionals including social workers.

Few scattered efforts in the form of certified training programmes were also taken place under the leadership of Shelja Sen, who is an expert in SFBT.

Academic training among Pre-PhD scholars in the area of psychiatric social work can be considered as the final curriculum wised skill development, hence Indian model of PhD course work emphasizes more on research methodologies. As per the best attempt of piecing the information from experts and scholars in psychiatric social work field, it is understood that none of the institutes among the prominent 10 institutes which offers MPhil in psychiatric social work has included SFBT part of the course work.

5 universities offering master's in social work fall into the top 15 universities of the country, as per the MHRD report 2016 (2). Among these universities only Pondicherry University have included SFBT in MSW curriculum. Among other Central universities SFBT is included as part of the curriculum only in Central University of Kerala, as the information collected by the authors.

SFBT; inclusion in research

The effectiveness and efficiency of any therapy is accepted on the basis of scientific research conducted in the field. The term evidence based practice is hard to describe about SFBT in India, due to lack of Indian studies in the area. 3 studies have published from India in which the study titled effectiveness of Solution Focused Brief Therapy for an adolescent girl with moderate depression by Pashupa Dharma Reddy et.al (3) was conducted by social work professionals. There is few more research conducted and presented in conferences and seminars on SFBT, but unpublished. The details of the studies could not be traced by the authors.

SFBT in NIMHANS

NIMHANS, being the Institute of National Importance is responsible to render the country with maximum quality services for promoting mental health. Scientific research on clinical and general population was always used to understand the efficiency of therapy, and practicing the model will be followed based on the evidence generated. The research study conducted by social workers (3) which has mentioned earlier in the paper was done by the professionals of psychiatric social work, department of NIMHANS. But the department has yet to included SFBT in the curriculum of PhD or Pre-PhD course work, however SFBT is covered in the additional micro skill training delivered for the Pre-PhD scholars. One day workshop on SFBT was conducted in 2016 aiming at encouraging professional to take up solution focused approach has served it's purpose. As a result the first case record with the positive findings of SFBT for psycho-social issues was submitted as part of the Pre- PhD course in psychiatric social work.

The interest of social workers in SFBT gave birth to a learner's group recently, under the supervision of Ijas Abdul Majeed, Junior Consultant in psychiatric social work and SFBT practitioner. The SFBT learner's group meets on a regular basis and organizes talk on SFBT techniques and skills to be attained as a practitioner. The group is an attempt to conduct case based learning of SFBT in the area of mental health and social work. The findings of SFBT as an intervention for dealing with psycho social issues, progress of the learner as a therapist of solution focused approach and challenges facing in the process also adds up to the discussion of the group.

Conclusion

Evidence based practice is a process of clinical decision making that integrates research evidence, clinical expertise and patient preferences and characteristics (4). It explains the importance of empowering a practitioner to make a clinical decision by contributing to research, academics and training in the field of SFBT in India, specifically social work setting to deal with the psycho-social issues of the client by using solution focused approach. Present situation of SFBT in Indian Social Work shows that we need to move upward in the scaling question.

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Dr. Santhosh was the co-investigator of EBTA granted project entitled "SF questions vs. PF questions: Effect on electrophysiological and neuropsychological components and affect". He has authored 18 publications (one book, two chapters and 15 journal articles) and is currently the primary investigator of the major research project entitled "Corporal punishment practices in modern families: Pervasiveness, consequences and solutions," funded by Centre for Research-Projects, Christ University. He is a) member of International Positive Psychology Association, b) professionally associated with Association of Solution Focused Practices-India, and c) voluntarily involved in the community extension activities supporting AMMAPSYCDAC Society for Mental Health (Palakkad, Kerala) in India.

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