Interview

1500 papers a year … An interview with Alasdair Macdonald

Interview by Mark McKergow

Dr Alasdair Macdonald is a consultant psychiatrist for children with challenging behaviour and learning disability. He is also a freelance trainer and consultant in SF, and has acted as research co-ordinator for the European Brief Therapy Association for well over a decade. The second edition of his acclaimed book Solution-Focused Therapy: Research, Theory and Practice has just been published by Sage.

How did you come to SF practice in the first place?

A zig-zag route through the psychotherapies – my father was a physician and psychotherapist, so I was exposed to conversations about this sort of thing at an early age. When I moved into mental health after qualification as a doctor, I wanted to be some kind of psychotherapist, and I found it more effective to work with adults and families. I was lucky to meet a very talented Persian child psychiatrist called Dr Rusty Framrose, who had a great interest in strategic therapy, which moved me towards that and then to SFT in the late 1980s. He was a very energetic chap and urged us all to move in that direction. He was very important – I realised how much more interesting and practical the brief therapies are for the current state of most healthcare systems.

We were running training clinics and workshops in strategic therapy at Crichton Royal Hospital in Dumfries (an environment deeply opposed to psychotherapy, which made it an interesting place to work). When SFT came along we thought we'd try it out. We did a six month trial with SFT in

1989 and were so happy with the improvement in our practice and our morale that we kept on with it – even though we were good at what we already did. We also researched our practice and studied our outcomes. The results were (in hindsight) what you'd expect: a 70% success rate (in terms of goal achievement) at one year follow-up. Compared to our previous work, it was a little better numerically and a lot better in terms of general satisfaction. The 'other' comments on the feedback questionnaire became almost uniformly positive. There was a change in the atmosphere of the sessions.

Where did you take it from there?

We set up a training programme locally, and then at the soon-to-become university in Carlisle (now part of the University of Central Lancashire). We trained anybody in health and social care at any level who wanted to know. They mostly had some kind of healthcare qualification – junior doctors, consultants, community and in-patient psychiatric nurses, GP counsellors, some GPs (general practitioner doctors), social workers, social worker managers – it made for very interesting groups.

The trainings went well, and the course is still running – it's a module within the university's portfolio and follows very much the same system, training followed by supervision groups for a number of months. In a later life I also trained quite a lot of local service managers on an advanced management course at the university. They were very pleased with it, went back to their local teams and started things off like getting training in for the teams.

One project was with a Family Regeneration Team (along the lines of work originally invented by Insoo Kim Berg for Michigan). I was the trainer and then the supervisor for the team. They worked in a very deprived area, it was a short intervention, which was very successful. Afterwards the families went back to social work treatment as usual, and about a third of them relapsed. There was obviously more to be done to integrate it into local services.

Also in Carlisle I was using SF in a secure psychiatric unit, in work with mentally disordered offenders – which was unusual then. It was pretty effective – they were good in-patient units anyway, and the incidence of violence went down and we were able to discharge people more quickly. This replicates the work of Kay Vaughn in Denver (Vaughn et al., 1996) – they found that the length of stay went down drastically.

How much has SFT caught on in in-patient settings?

Within mental health in the UK, SF approaches are 'officially' used in drug and alcohol programmes and with learning disabilities. Unofficially it's used by a wide range of other practitioners, but not adopted as an official model. In the UK (and in the USA) there isn't really an official model for lots of things – once you have your qualification, you can do what you like. As long as you get good results and there are no complaints, that's OK.

IAPT (Increasing Access to Psychological Therapies, a UK programme to reduce waiting lists for therapy treatment) has been largely hijacked by Cognitive Behavioural Therapy (CBT) people. In some places you are not allowed to practise SF in this programme, you have to have CBT courses and use CBT, which is a shame as it would be a good fit. It's a political issue, not a practice issue. Workers in some areas have lost their jobs because they are not CBT qualified.

You are the EBTA Research Co-ordinator – how did you get into that?

The first EBTA conference that I attended (Stockholm, 1994) was quite a small number of people, and we decided to pull together whatever knowledge there was. Because I had presented the first outcome research data at that meeting, I was asked to co-ordinate the research for a while. At that time there were only eight published outcome studies, so it was assumed it was a fairly easy task.

Somebody then suggested that rather than just listing the studies, it would be good to have a summary of each so that people could see what each one was about. That made the task much larger in terms of time. It has also expanded a great deal over the years – this year there are about 1500 papers coming out when you Google solution-focused (though many of these are not outcome studies or even good quality academic work). That's quite a lot of papers. You would struggle to qualify a lot of them in terms of good quality academic research – there are lots of people saying that 'I get good results with my patients' without giving the details.

Wow, that sounds like a huge number… do you look at all the papers?

Google Scholar is very useful here – you get a one line summary, then you can decide whether it's worth following up. Then you have to get hold of it - often the author will send you one. Last year I had to buy about 15 papers. I did it three times during the year, picking up about 8-15 papers each time to examine closely, with just one or two of those going through to the list as good quality research.

What happens to the other papers?

I keep the more interesting ones – there was one in using SF in IT breakdowns, which is showing it spreading to new fields. A lot of the work is done in other countries and other languages, which makes it all the more challenging.

Could you please summarise the current situation about the research base…

There are 111 good published outcome research studies, 19 randomised controlled trials of which 9 show SF to be better than other approaches, and 45 comparison studies of which 36 show more benefit from SF than the alternative treatment-as-usual. Then there is lower grade information – some 5000

individual cases have been followed up, with about 70% success rate (i.e. the patients were better at the time of follow up). The comparison studies are more important as evidence – it's like comparing electricity with gas in your home and asking which is better, whereas the follow-ups are like only looking at the difference between electricity and no electricity – there is no comparison. It's all online at www.solutionsdoc.co.uk.

That's very impressive – how does it compare with the research base of other approaches?

Alan Carr's (2009) book 'What Works with Children, Adolescents and Adults' collects comparable data for psychotherapy studies. It shows that most psychotherapies have been shown to be effective but that one is not generally better than another. Wampold (2001) reanalysed CBT for depression and said it wasn't that good. So, other models can show extensive research, but dispassionate analysis of the outcome doesn't show advantage for any particular model.

It's widely said that the Wampold research shows that the model doesn't make much difference anyway?

Yes – Wampold showed all psychotherapies work, and they work for about 70% of people. However, he also showed that if the therapist liked the model they used, they get better results. The same is true of the clients. So, having a range of models available is a useful contribution to outcome.

So what are the advantages of SF over other models?

The client spends the minimum time with the therapist and the maximum time doing things to move forward. So it's more efficient for them both. Also it's good for building independence of the client – client autonomy – they are taking their own responsibilities and that builds self-confidence and hope.

Sometimes people say SF lacks credibility…

In principle in science everything is driven by evidence, but in reality it's the professor with the loudest voice who gets the most money for their department. There are very few SF academics and professors – Mark Beyebach in Spain, Cynthia Franklin and Frank Thomas in Texas, Thorana Nelson in Utah, Wei-Su Hsu in Taiwan. There are also vested interests where existing departments run along other lines, and they are slow to absorb new ideas.

How might we improve the credibility?

One of the difficulties is that people like to talk about problems, and if you are setting up a new organisation it's often around a certain problem. SF doesn't fit into this very well as we don't do diagnosis and problems in the same way. When NICE (the UK National Institute for Clinical Excellence) do a literature search for a new guideline, they search on the diagnosis – and so the SF work doesn't appear.

Should we be setting aside our qualms about diagnosis then?

I have been involved with the EBTA research grant awards and I proposed to EBTA colleagues that we should ask for diagnostic words in the titles of the research we support with grants, but they felt that would be contaminating our ideas. But that would be one way through it, simply retitling the research work.

A word on how SF has spread from therapy to all kinds of other fields . . .

It's gone in two ways. In the therapy world, other therapies are morphing towards SF and narrative – motivational interviewing, mindfulness, hypnotherapy, NLP, CBT. These are all beginning to look like SF or like narrative (and there is a

great deal of overlap between SF and narrative). These things are all running together in some way. In CBT trainings now they ask about what's going well and what can you do more of (which sounds rather familiar), where they used to ask about what's gone badly and what do you want to change.

In other contexts like organisation work, there is more freedom to go the way you want to go and as long as you can show results... In many ways the business world is better managed than the medical world – there are clear endpoints. Is profit up? Is absence down? You can set out to experiment with things. On the other hand, people are less bothered about quite what it is as long as it works, so they may say 'We got Mark McKergow in and everything's gone very well since' rather than 'he did SF'. There is, however, a growing amount of research of SF in the workplace, much more than most other models. This is where SFCT is playing a role. It gives a quality badge and it takes it beyond a particular worker to a recognised field.

You've been in this since nearly the start – what are your thoughts for the future?

There are several contexts. Within the UK therapy context we will continue to make inroads – staff do better and there is less burnout. We are accumulating evidence that SF is good for you, the organisation and the client. Also some IAPT services are being privatised and that offers opportunities for SF.

Within the wider therapy world, IASTI (the International Alliance of SF Training Institutes, see our interview with Luc Isebaert in Volume 3 Issue 2) seems to be setting itself up to regulate international standards in SF training, although there has been little in the way of public announcement. However, many people who are already doing SF don't care tuppence for regulation so it remains to be seen how successful this will be.

In the wider world of business and organisation, I hope and

believe that SFCT and other work such as Anthony Grant's papers mean that it's getting a much higher profile. I hope it will spread to China and India too – there has not been a lot of activity there yet, at least not visibly. A small number of people have been invited to India to do SF training. Insoo did some training in China and I've done some. So far the Chinese have asked me mainly for therapy training rather than organisational training.

Thank you very much.

References

Carr, A. (2009). *What Works With Children, Adolescents And Adults*. London: Routledge.

Vaughn, K., Young, B. C., Webster, D. C., & Thomas, M. (1996). A continuum-of-care model for in-patient psychiatric treatment. In S. D. Miller, M. A. Hubble, & B. L. Duncan (Eds.), *Handbook of solution-focused brief therapy* (1st ed., pp. 99–127). San Francisco: Jossey-Bass Publishers.

Wampold, B. E. (2001). *The Great Psychotherapy Debate: Models, Methods, and Findings*. Hoboken: Taylor & Francis Ltd.

Wampold, B.E., Minami, T., Baskin, T.W., & Tierney, S.C. (2002). 'A meta-(re)analysis of the effects of cognitive therapy versus "other therapies" for depression'. *Journal of Affective Disorders*, (*68*), 159–65.