Peer-reviewed papers

Solution Focused Formulations

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Abstract

Problem formulations are often said to be essential to ethical therapeutic interventions by professionals working therapeutically in mental health. These formulations provide an explanation of the problem along with a road map of what needs to change to ameliorate the problem. The lack of focus on problems puts solution focused work at odds with most other mainstream therapies, and a lack of problem formulation is but one of the differences thrown up by working in a solution focused way. The author describes very briefly the history of problem formulations then describes how SF work addresses some of the features said to be common to these formulations. A diagram of a possible SF formulation is given. It is the author's conclusion that SF workers do a type of co-formulation with clients that meets many of the 'requirements' of a problem formulation process. There is much more work needed to determine whether or not SF therapists wish to engage in a type of formulating or whether we, as a group, adopt the stance that formulations are not established as necessary for ethical, effective therapeutic working.

Introduction

Recent psychiatric (e.g. Goldman, 2012; Mace & Binyon, 2005; 2006), psychological (e.g. British Psychological Society (BPS), 2011; Johnstone & Dallos, 2014) and mental health nursing literature (e.g. Crowe, Carlyle & Farmer, 2008) makes it clear that clinical problem formulations (also

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called 'case' formulations) are a central aspect of good, competent client care. These disciplines place specific emphasis on the importance of any problem formulations, regardless of the theoretical base. For example, Goldman (2012) writes from a psychiatrist's point of view that a formulation is *critical* not only in order to put a client's problems into an explanatory model, but also to give a road map for the treatment and provide a yardstick by which treatment efficacy can be measured. The Division of Clinical Psychology, within the governing body of the BPS (2011), considers formulation as a *core skill* for clinical psychologists in all areas of practice. In psychiatric nursing (Crowe, Carlyle & Farmer, 2008) formulations are regarded as *central* to organising assessment findings and developing, as well as interpreting, the meaning attributed to issues the client brings to the assessment process.

Literature makes some distinctions between the *process* of formulating treatment for problems and the production of a formulation as a tangible *outcome* to guide treatment. Both the process and the outcome of formulation are seen as necessary to link psychological theory to practice (BPS, 2011) which ensures that a therapist is using interventions that are well-grounded in widely accepted theoretical principles. Formulation is considered a first step in ethical intervention to such an extent that many therapists believe it is unwise to proceed without it.

Yet, formulations of this nature do not feature in Solution Focused Brief Therapy (SFBT). As the practice of SFBT progresses, will it be open to criticisms of being unethical because formulation is considered to be critical or essential to ethical clinical work? Where would a lack of formulation leave SFBT as a practice? Is there a way to formulate within SFBT without sacrificing the underpinning principles of the work? Answering these types of questions relies on a good understanding of what constitutes a good case formulation. After that, we are in a position to determine whether or not any aspect of case formulation fits within SFBT.

Background of case formulation

According to Butler (1998, cited in Johnstone and Dallos, 2014), the process of completing formulations is a co-constructed and iterative one. Butler says formulation frequently requires review and revision because the cause and effects of a person's problems are not knowable all at once. Further, he identifies a formulation as a means to clarifying a therapist's hypothesis about what needs to change and as a way of prioritising essential areas of work from secondary areas. We know that the therapist's hypotheses are based on their theoretical orientation (such as behavioural, medical, psychodynamic etc.) which determines the choice of treatment strategy and helps predict which treatments are most likely to work. Formulations are understood as a means of explaining the therapist's theory of change, and will vary considerably depending upon the theoretical beliefs of the therapist.

The practice of formulating a client's problems arose within the context of therapy as a medically oriented science (Johnstone & Dallos, 2014; BPS, 2011). Case formulation makes perfect sense when professionals, many of whom are medically trained, assume that people have problems within themselves that require treatment. In a very basic medical form, a person who presents to a psychiatrist with a certain set of behaviours, having been subjected to various tests, may be said to have depression (presenting problem). As a first treatment, the medical practitioner may believe the patient has an imbalance in his or her neurotransmitters (i.e. an aetiology which is a medical term for cause of the problem). He will be prescribed an anti-depressant (treatment) and given a prognosis (a medical term for outcome) of recovery so long as he faithfully takes his tablets. A formulation following the medical school of thought requires mental ill health resulting in presenting problems for which there is an aetiology (cause) that will respond to a treatment for which a prognosis (outcome) can be given. Within a medical field where it is assumed people with common problems will benefit from prescribed solutions, it is clearly necessary for treatment to

come from a transparent understanding of the problem and from prescription of the most helpful treatment for that problem. It was, and still is, unethical for a professional to act upon a person's problems without an understanding of why he is using one intervention over another.

Not all therapeutic interactions are medically based however. One might assume that moving away from a medically based view of psychological problems would have made formulations obsolete, but this has not been the case. Rather, formulations continue to be a critical step in most of the mainstream schools of talking therapy. For example, psychoanalytic therapy, in very basic terms, starts with the assumption that a person's presenting problem will be related to unfinished relationship issues within the family of origin. The usual treatment for a problem viewed from this view point would be lengthy and frequent talking therapy where the expert therapist helps the client discover the errors in how they have coped with past relationships. The formulation in psychoanalytic therapy would locate the presenting problem within the person who has not dealt well enough with poor past relationships.

A different school of thought is Cognitive Behaviour Therapy (CBT). This is a very popular type of therapy in which the expert therapist helps the client understand their presenting problem as a result of 'crooked' thinking. CBT is based on the client understanding how their thoughts influence their feelings or emotions and how both in turn impact their behaviours. A change in one of these constructs (thoughts, feelings or behaviours) will result in a change in the other two constructs. Thus a CBT formulation would have the client believe that their presenting problem is again located within themselves as they have developed erroneous thoughts and furthermore developed erroneous feelings and behaviours to support those thoughts.

These three examples show that the same person may be told that their depression is a result of a chemical imbalance in their brain, the result of a repressed childhood trauma or the result of irrational thinking, depending upon the theoretical

leanings of the person making the formulation. How is the client to understand the different meanings made of their problem? Which formulation is more right? Which formulation is the most ethical? Which formulation is most useful to the person? There has been limited research addressing these questions, which is surprising for such a highly valued construct.

Given this lack of research, it seems not to matter whether a formulation is based within a cognitive behavioural, a psychoanalytic or any other type of theoretical basis. For all the importance given to a formulation (remember it is 'critical' to ethical practice), the above questions have not been answered by robust research. As Bieling and Kuyken (2003) rightly suggest, formulations need to be subject to evidence-based research in terms of reliability (would different therapists come up with the same formulation?), validity (does formulation relate meaningfully to the presenting problem?) and outcome (does formulating lead to a positive outcome and if so for whom?). Additionally, there are no standard parameters agreed between therapists of differing schools of thought in terms of what are the important aspects by which formulations could be measured across different therapies. There have been a few checklists by which a formulation could be evaluated (e.g. Butler, 1998 as cited in Johnstone, 2014), but no work has been done across various types of therapy to develop one coherent format.

Johnstone (2014) does a nice job of summarising the debates surrounding the use of formulations. She addresses the paucity of research relating to the reliability and validity of formulations and, in her thorough review of literature, she has found that some therapists from the same school of training can agree on their identification of the problems that brought the person to therapy, but they cannot agree about why the problems arose in the first place (Persons, Mooney & Padesky, 1995; Kuyken, Fothergill, Musa & Chadwick, 2005; Luborsky & Crits-Christoph, 1990 as cited in Johnstone, 2014).

There is also very little research within the differing fields of therapy to ascertain the usefulness, to clients, of any type of

formulation and the outcome of the therapy. Again, according to Johnstone (2014), apart from the one article, which is mentioned next, there is no research on the client's view of the effect of formulations to the outcome of the therapy. Chadwick, Williams & Mackenzie (2003) addressed the impact of cognitive formulations on anxiety and depression and found clients felt no significant effect as a result of the formulations. According to the author of this paper, the lack of good research also weakens the claim that formulation as a construct or as a process is critical to ethical therapy. There can be no claim that a formulation is needed in order for therapy to have a good outcome as measured by the client.

It may be too early in the life of case formulations for SFBT practitioners to worry about not using traditional formulation behaviour when there has yet to be robust research about the reliability, validity and usefulness of formulation to outcomes. It may also be too early in the development of the important aspects of a formulation to consider that this therapeutic activity is critical or even essential to ethical therapy. In fact, it seems the best that can be said is that any therapeutic action upon a client's problems, without an understanding of why the therapist is using one approach over a different one, amounts to unethical practice. In the world of SFBT this means that practitioners need to be conversant in the principles that underpin why we ask the questions that we do, how we select aspects of the client's answers on which to gather detail, and how we continually privilege the language and view of the client, even when the client's understanding of their issues does not match initially with the therapist's view of the same issues. If an SF therapist can answer these questions about any aspect of their interaction with a client, that may well be superior to the development of the relatively undefined, under-researched process of case formulation.

Solution Focused Work and the Process of Formulating

Fundamentally, formulations require a focus on problems which are thought to require explanation and resolution through expert interventions. SF therapists do not focus on a person's problems, therefore we would not seek to explain or resolve problems, and we would not assume an expert stance either in terms of understanding / explaining problems or in constructing theoretically driven interventions. SF therapists would not have any idea as to whether chemical imbalance, irrational thinking or early learning might be important for the person to address; therefore an SF therapist could not construct a problem formulation in the typical sense. In SF therapy, professionals actively give priority to the expert client's view. SF professionals definitely do not 'know best'. To go even one step further, SF therapists are not concerned with discovering the cause or prescribing a fix for someone's difficulties. Thus it appears quite clear that we do not aim for the production of a road map based on a formulation for problem resolution.

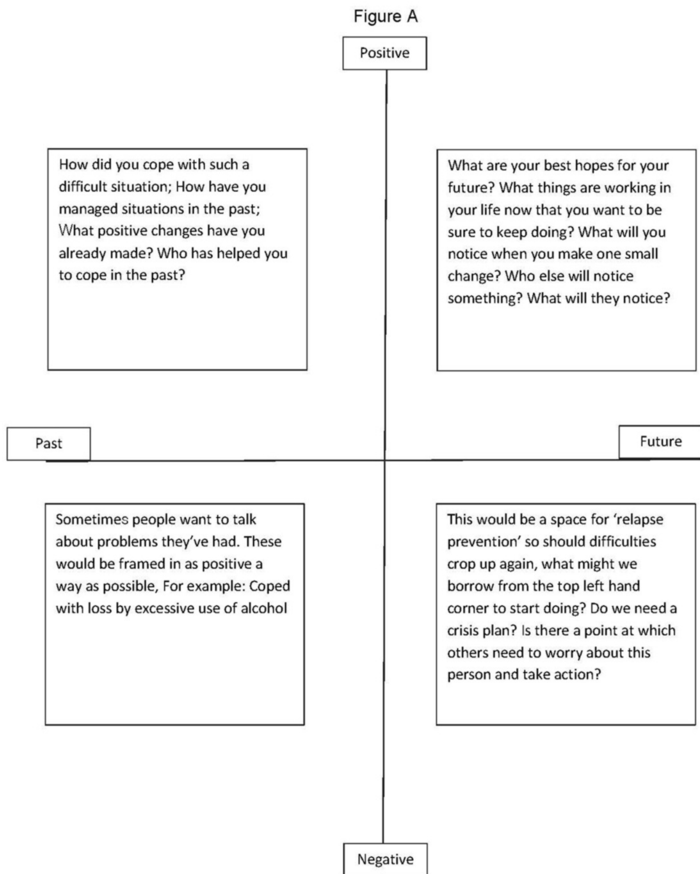
What SF therapists do quite well however, is engage in a co-constructed, iterative dialogue with the person to produce a joint understanding of what the person would like to achieve, what resources the person might already have that might help to move forward and what they will notice when they are inching towards their preferred future. People have a very natural instinct to make sense of things, to tell their stories and to find reasons (as opposed to causes) for things being the way they are (Curtis, 2013) and SF therapy privileges the person's view in these matters. Where CBT might see 'crooked thinking' as the cause of a person's sadness, SFBT would ask "How have you coped with this sadness before?" We would not seek to establish a detailed description of the problem, preferring instead to seek a detailed description of what resources the person has that could be applied to the problem. We can co-create a roadmap towards the person's preferred future using existing resources and coping skills. Our history taking is one of collecting competencies as opposed to

collecting problem details. To this extent, SF therapists could be seen to engage in the process of formulating as it applies to finding a road map forward, but not as formulation applies to describing presenting problems and historical causes for those problems (Muir, 2013). A tool to help SF therapists formulate a road map for the way forward is the focus for the remainder of this article.

If SF practitioners choose to accept the challenge of producing a formulation as a road map, the formulation will have to be in a format that privileges the client's view as expert as well as emphasising movement towards the client's preferred future. One suggestion for a formulation map presented in this article is along two continuums. The first is positive or negative and the second is past or future. When these two dimensions intersect each other, the SF therapist and client will have four quadrants on which to focus their discussion. The map serves to help the therapist and client decide which of the four quadrants will produce the most helpful discussions as well as help to collect important information in all the quadrants. As an aide memoire, the quadrants might ensure that important information is covered by the therapist, even if that means talking about the 'problem/past', which some trainers suggest ought not be done in SF work.

There have been many excellent books and articles explaining the principles and structure of SF therapy, (cf. Trepper, McCollum, de Jong, Korman, Gingerich & Franklin, 2010; O'Connell, 2005) so the approach will not be described in detail again here. These resources will help us now identify how SF therapists might use Figure A as a means of formulating a road map into the client's preferred future.

In the upper left quadrant, the invitation is to talk in positive terms about the past. SF therapy is not known for emphasis on the past, as priority is given to considering the person's preferred future. However the person comes to therapy with a long history of coping with difficulties as well as a long history of successes which we want to be sure we know about as we plan for a successful future. One feature of SF therapy is asking the client whether or not anything has improved since



the appointment was made to meet with the therapist. This is called pre-session or between-session change (O'Connell, 2005) and is one of the hallmarks of SFBT. Also, SF therapists engage in 'coping' questions (Lipchik, 1988), which allow the therapist and client to talk about the past in terms of past successes as well as current successes which can be listed on a separate sheet along with other 'here and now' information. Competence-seeking is necessary for both the therapist and client to discover and affirm the resources, strengths and

qualities which the client can use to achieve their best hopes (de Shazer, 1988).

In the upper right quadrant, the invitation is to talk in great detail about what the person's preferred future will look like. This quadrant will, in an SF session, contain the most information as the therapist and client break down concepts such as 'be happier' into the many constituent parts so that both know what to look for as the person becomes 'happier'. This is where the Miracle Question (de Shazer, 1988) as one means of establishing a preferred future would fit well. The discussion here, in terms of the person's preferred future or best hopes for therapy, needs to focus on the detail of those best hopes. This quadrant will be filled by questions such as 'what else?' in order to help the client establish a good detailed picture of their future.

The lower left quadrant is reserved for talking about the past difficulties. Whilst SF therapy does not focus on problems, it would be inaccurate to say that practitioners ignore or refuse to discuss a person's problems. Sometimes it is useful to establish a list of the things that have gone wrong in order to point out to the person how much they have already coped with. It is also useful for some people to highlight the very things they do not want to slip back into, as they experiment with new ways to reach their preferred future. It is frequently part of a person's expectation when they come to therapy that they will get to talk about how bad things have been, and in some instances to talk about what solutions they attempted that didn't quite work in the long term. SF therapists will, of course, participate in these discussions to the extent the person shows it is helpful. Additionally, talking about the problems of the past can lead to the discovery of exceptions to the problem. Focusing on this quadrant may lead to discussion about what the person did, or what others did, that made the problems less problematic, and that can be useful for future work. Additionally, there are times when SF therapists work with people who present significant risk to themselves and/or other people. In common with any ethical therapy, SF workers will take account of this and co-construct a crisis plan if one is

required. At this point, the SF worker moves from a therapeutic stance to become an agent of social control, ensuring the safety of all concerned as a priority.

And finally, the lower right quadrant is where crisis intervention could be discussed. This section is often follows on from discussions of the lower left quadrant as the therapist and client highlight ways to cope, and actions to be put in place, if the person starts to slide back into their previous problematic behaviours. This is the place where, when acting as an agent of social control, the therapist would write the detail of the protocol that will be followed to ensure the client and others are kept safe. In a very good SF formulation, there would also be an indication as to how the client and others will know they are safe enough for any restrictions to be lifted so that supporting the person to move forward can be reinstated.

By co-constructing the information on a visual map such as the one presented, both the SF therapist and the person can see the growing list of competencies, skills and positive effort attributable to the person. Visually it is clear that the main emphasis of the work is on the positive aspects of the person and their environments as well as a focus on the future rather than the past.

Based on a small number of trials by the author, this way of structuring and the iterative process that occurs during SF therapy is mixed. At any point during the therapy, either participant can stop and establish which quadrant is being addressed and make a conscious decision as to the usefulness of that conversation. It gives a visual representation of the limited role problems play within the life of a person who has already coped with many stresses and traumas. As sessions progress, the map grows through the discovery of more and more skills, as small steps towards a preferred future are taken and as other changes are made. One difficulty with the map is the placement of information about the 'here and now' as the map only focuses on the past and the future. A possible way around this difficulty is a separate sheet of paper to describe how things are right now. If it turns out to be helpful, the here and now information can then be mapped onto the future

oriented quadrants, where the person can identify what it is about their current situation that they want to be sure to keep going into their future.

The view as to the usefulness of the map, to the clinician, to the client or to positive outcomes has been mixed, based on a very small number of trials. As the therapist using the structure, I found it very helpful in keeping my focus clearly on the future, as it is easy to point to which quadrant is presently under discussion at any one time. Clients felt it was an odd and surprising thing, and at the same time useful because it made it clear what different kinds of discussions were being held. Neither I nor any client identified the structure as specifically contributing to a positive therapeutic outcome, however. The structure took its place in the background of therapy whilst credit for a positive outcome was left with the client, which is in keeping with the principles of SF therapy.

Clearly, significantly more work is needed using the map within sessions to produce any significant data on its usefulness, or otherwise, as a means of structuring SF conversations and to determine whether or not the map is associated with positive outcomes for the person. Additionally, views from SF therapists need to be sought to establish whether or not the map fills a need in terms of SF formulations. Indeed, future work is required within the SF field to ascertain whether or not practitioners wish to embrace any type of formulation within their work, as the need to do this cannot be assumed. SF therapy is working rather well as it is in terms of producing positive outcomes (Gingerich & Peterson, 2012) and in terms of being a positive process (McKeel, 1996 / 2014) and we would not generally try to 'fix' something that isn't broken. At the same time, we as a group of practitioners are subject to the same ethical scrutiny as other schools of thought. If the use of formulations continues to be thought of as essential to ethical working, then we do need to consider use of such within our practice.

Conclusion

Formulations, in the traditional sense of describing the presenting problems, understanding why those problems arose, understanding why they are continuing to occur and from which a treatment can be prescribed as well as evaluated, are rooted in the past establishment of mental health work as a scientific endeavour that can sit alongside medical work. Formulations as described in this way continue to form the basis of many traditions of psychotherapeutic work and, despite a lack of underpinning research, continue to be considered essential to ethical working. SF workers do not use case formulations in this traditional way.

However, inasmuch as formulations set clinical work within a system of therapeutic principles and make transparent the basis of the clinical work, SF practitioners could be said to engage in the process of formulating. SF formulations will show the goals the person wants to achieve, what existing skills they already have to move towards their goals and identify the series of small steps needed to attain their goal.

A map that could be used to structure SF formulations has been proposed; however no structured research has been conducted on the use of the map. The applicability of the map to any formulating process and, perhaps most importantly, the views of people engaging in SF therapy in terms of the helpfulness of the map in attaining a positive therapeutic outcome have not been addressed. These remain areas for future work.

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