20. Applications of Solution-Focused Brief Therapy in Suicide Prevention

HEATHER FISKE

Solution-focused brief therapy (SFBT) has been described as part of a “mega-trend” in psychotherapy in which the focus of treatment has shifted “away from explanations, problems, and pathology, and toward solutions, competence, and capabilities” (O’Hanlon & Weiner-Davis, 1989, p.6). SFBT has much in common with other, earlier models as well – for example, with the optimism and fostering of self-efficacy in Ringel’s Adlerian approach to suicide prevention (Diekstra, 1995). The approach has been developed by Insoo Kim Berg, Steve de Shazer and their colleagues at the Brief Family Therapy Center in Milwaukee (de Shazer 1988, 1994; de Shazer, Berg, Lipchik, Nunnally, Molnar, Gingerich, & Weiner-Davis, 1986; Kral & Kowalski, 1989; Nunnally, de Shazer, Lipchik, & Berg, 1987; Walters & Peller, 1992; Weiner-Davis, de Shazer, & Gingerich, 1987). Applications in a wide variety of settings and populations have had positive results (e.g. Berg, 1994a; Berg & Miller, 1994; Booker & Blymer, 1994; Dolan, 1992; Ingersoll-Dayton & Rader, 1993; Kral & Schaffer, 1989; Mc Farland, 1995; Peller & Walters, 1989; Plaxton, 1995; Weiner-Davis, 1987).

SFBT is a respectful and empowering approach which in my view has much to offer in clinical suicide prevention. In particular, solution-focused work may allow helpers to begin the “search for solutions” immediately, even during crisis intervention. In addition, solution-focused techniques may provide tools for decreasing perceptual constriction, working with ambivalence, facilitating early communication of intent, and developing workable alternatives to suicide which are consistent with individual needs.

In this paper I will briefly outline the central philosophy and assumptions of SFBT, and describe some of the associated therapeutic techniques which may be helpful in clinical suicide prevention work. As a general framework for discussing SFBT applications, I will use Shneidman’s “Ten commonalities of suicide” (Shneidman, 1987, 1989). The “ten commonalities” are presented here, not as a definitive or comprehensive description of the suicidal person, but as a vehicle for illustrating some typical concerns and issues in suicide prevention. My intention in choosing this format is to give interested clinicians
a sense of how this model can be applied in addressing such concerns and issues.

I. SFBT Philosophy and Assumptions

A. The Central Philosophy

Berg and de Shazer have expressed the Central Philosophy of Solution-Focused Brief Therapy in three succinct “rules of thumb”:

 Rule 1: If it isn’t broken, don’t fix it.
 Rule 2: If it’s working, do more of it.
 Rule 3: If it’s not working – do something else.

These guidelines can provide a pragmatic standard against which helping professionals can evaluate their clinical work on a continuing basis:

– Am I attending to the problem presented, or getting off course, following my own agenda? (Rule 1)
– How can I maximize what I am doing that is effective? (Rule 2)
– What can I do differently instead of what is not working? (Rule 3)

In crisis intervention situations, there may be multiple problems, multiple options, and limited time in which to evaluate the information. Reference to the Central Philosophy can help interveners to focus, and stay focused, on the most effective course of action.

B. Assumptions

Talking solutions.

A fundamental assumption of solution-focused work is that “Focusing on the positive, the solution, and the future facilitates change in the desired direction (Walters & Peller, 1992, p.10). As a result, solution-oriented talk is seen as a more valuable focus than problem-oriented talk. This shift in focus is a profound change for most traditionally-trained mental health professionals – but it is only a shift, not a complete departure. Problem definition is still an important part of a solution-focused therapeutic process; inviting clients to tell us their stories and listening reflectively remain fundamental. Careful listening and clinical judgement help to determine the most appropriate timing for introducing “solution talk”.

One of the key aspects of “solution talk” is the emphasis on exceptions to the problem, on those times when something other than the problem is occurring. Such exceptions invariably occur, even when the problems seem particularly pervasive: as de Shazer says, “nothing always happens”. In solution-focused therapy, it is assumed that exceptions to the problem can be used as a foundation to build solutions.