Brief therapy in adult psychiatry – further outcomes

Alasdair J. Macdonald

A report of a one-year follow-up of thirty-six referrals treated with solution-focused brief therapy by a supervised team in a mental health setting is described. A good outcome was reported for twenty-three cases (64%). These results are comparable with our previous work and with one other statistically validated outcome study on solution-focused therapy.

Introduction

As financial stringency begins to affect healthcare in all countries, there is an increasing need for outcome studies in order to guide the work of individual practitioners and to allow rational decisions about expenditure on services. Our team has practised solution-focused brief therapy in the context of adult mental health for six years. In a previous study of our first three years’ work (Macdonald, 1994), we reported a good outcome for 70% of our referrals and we now report results from a further cohort of referrals seen over a subsequent three-year period.

Therapeutic approach

We work as a multi-disciplinary team using live supervision for both trainees and experienced therapists. We serve a scattered rural population and usually see attenders once a month. Our referrals come from general practitioners and colleagues in the mental health services. The team does not act as the first point of contact for those with an acute psychosis but all other referrals are seen at least once. The problems presented by our attenders are similar to those seen at local psychiatric outpatient clinics.

A letter is sent to all referrals describing the team approach and

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notifying them of their rights in relation to videotaping. This follows the suggestions of Birch (1990) about the value of pre-
session contacts and consent procedures in setting a context for
therapy. The letter invites clients to contact us for an appointment
and suggests that they will have started making changes before they
see us. We send a written copy of the closing intervention to the
attenders after each session which reinforces our comments during
the interval between meetings and is generally appreciated by atten-
ders.

We use a solution-focused brief therapy model (de Shazer, 1994;
Macdonald, 1994). Sessions revolve around goals chosen by the
attenders. Exceptions to the existing problem are emphasized in
discussion, and scaling of problems from 1–10 is used to provide a
neutral way of assessing change and to assist discussion about small
steps on the way to the goal. The ‘miracle question’: ‘What if a mir-
acle happens and the problem is solved?’ is used to develop a
picture of a new and better future towards which attenders can
move.

Follow-up design

As in our 1994 study, we sent follow-up questionnaires by post to
attenders and their general practitioners one year after their last
session (see Appendix). The questions were derived from
Watzlawick et al. (1974) and de Shazer (1985) and sought informa-
tion about the problem, goal achievement, any new problems and
any further advice sought from other professionals. Comments on
the therapy style in general were also requested from all parties. A
second set of questionnaires was sent out six weeks later if no replies
were received. (The study received the approval of the Dumfries
and Galloway Ethical (Research) Committee. Statistical calculations
followed Siegel (1956) and Swinscow (1983).)

Results

Over the three-year period, forty-seven referrals were received and
thirty-nine were seen. Follow-up information was collected success-
fully on thirty-six cases. Replies were received from twenty attenders
or groups of attenders (56%) and thirty-four general practitioners
(94%). In sixteen cases general practitioners replied but attenders
did not. In two cases only the attenders replied. This high rate of
return by general practitioners is usual for Dumfries and Galloway but unusual elsewhere in the United Kingdom, and reflects the supportive nature of general practice in the region.

Consultant psychiatrists made twenty-seven referrals and general practitioners nine. The identified patients ranged in age from 18–63 years (mean 36.03 SD 11.79). Nineteen were male and seventeen female. Four identified patients were in hospital at the time of referral. Fourteen individuals, eighteen couples and four families attended for therapy. The social class distribution of the sample differed from the local population as shown in Table 1.

The number of monthly sessions ranged from one to twelve (mean 3.28 SD 2.39). There was no difference in number of sessions attended by age, sex or outcome. This differs from our previous study in which male identified patients had fewer sessions and those attenders who reported a good outcome had more sessions. Eleven therapies ended by mutual agreement and twenty-five ended by a lapse from attendance. Those who lapsed were advised by letter that they had ‘sessions in reserve if required’. There were no significant differences on any variable between those who lapsed from attendance and those who were formally discharged. This finding is similar to the situation in British general practice where recovery is assumed if the patient does not make further contact with the practitioner.

Outcome

‘Good outcome’ means either that attenders themselves reported that the problem was better, or that the general practitioner reported that the problem was better if information from the attenders was not available. Responses from attenders were preferred in

<table>
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<th>TABLE 1</th>
<th>Social class distribution</th>
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<tr>
<td>Population (%)</td>
<td>3.62</td>
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<tr>
<td>Sample (%)</td>
<td>13.9</td>
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<tr>
<td>Good outcome*</td>
<td>5</td>
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<td>Others*</td>
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* = Difference between ‘Good outcome’ and ‘Others’ groups not significant (Wilcoxon Rank Sum Test (Unpaired))
all cases if there was a choice. By this definition a good outcome was
found in twenty-three cases (64%), while three were worse and ten
were unchanged. There was no significant difference overall
between outcomes reported by patients and those reported by
general practitioners.

The ‘good outcome’ group was aged 19–63 years (mean 38.22 SD
12.36). There were fourteen male and nine female identified
patients. Sixteen had been referred by consultants and seven by
general practitioners. The group included nine individuals, eleven
couples and three families. The number of sessions attended
ranged from one to eight (mean 3.35 SD 2.08). Five ‘good
outcome’ cases and three of the remainder of the sample had only
attended one session. The ‘good outcome’ group did not differ
significantly from the rest on any of these variables.

Similarly, the ‘good outcome’ group did not differ from the
remainder as regards district of residence, whether discharged or
lapsed from attendance, whether in hospital at the time of referral
or social class distribution (see Table 1).

The duration of the presenting problem is shown in Table 2.
There were more long-term problems in the ‘worst’ and
‘unchanged’ groups. Two of these cases gave additional details in
their replies. In one reply, the goal had been achieved but new
problems had arisen requiring further advice from other profes-
sionals. In another case the goal had not been achieved and new
problems had also arisen.

Problems and goals were defined in the attenders’ own words. A
good outcome was reported in seven of the thirteen with relation-
ship difficulties, eight of the eleven with anxiety or tension, six of
the nine with depressive complaints and two of the three with exces-
sive use of alcohol or tablets. Positive goals had been identified by
twenty-five and negative goals (i.e. to stop or reduce some under-
desired activity) by eleven. For the ‘good outcome’ group the figures

<table>
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<th>TABLE 2 Duration of presenting problem</th>
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<td>Short (&lt; 1 year)</td>
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<td>Good outcome</td>
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<td>Others*</td>
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* = Significantly more ‘long-term’ cases in ‘Others’ group $p < 0.05$ ($\chi^2 = 7.399$ d.f.2)
were fifteen and eight respectively. Eighteen respondents commented on their achievement of specific goals. Of those who replied on this point, nine in the ‘good outcome’ group had achieved their specified goals and five had achieved part of their goals. Two of the remainder of the sample had achieved their goals and two had not. These differences were not statistically significant. No information about goal achievement was available for the remaining cases.

Table 3 shows the replies given to the other questions. Significantly more in the ‘good outcome’ group had solved other problems in addition to their presenting problem. Significantly fewer new problems had arisen for the ‘good outcome’ group. Only a small number reported consulting other mental health professionals since therapy ended and there was no significant difference between the groups on this point.

Favourable comments about therapy such as ‘useful to draw attention to positive aspects of situation’ were made in twelve replies and unfavourable comments such as ‘disliked the emphasis on making changes’ in eight. These comments showed no correlation with other factors studied including outcome and goal achievement; in other words, neither compliments nor criticism about therapy style were shown to be linked with outcome.

Of the thirteen in the remainder of the sample, ten were unchanged and three worse. Of these latter, two were female and one male identified patients, all in social class 111N; their mean age did not vary from the remainder of the sample. Relationship problems affected two patients, and one was anxious. Two problems

<table>
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<th>TABLE 3 Additional findings</th>
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<td>Good outcome</td>
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<td>Others</td>
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Significantly more ‘other problems solved’ in ‘Good outcome’ group $p < 0.038$ (binomial test)
Significantly fewer ‘new problems’ in ‘Good outcome’ group $p = 0.025$ (Fisher exact probability test)
were of short duration and one was longstanding. All had chosen positive goals. The male aged 24 years (the youngest in the ‘worse’ group) reported the solving of his short-term relationship problem but had encountered new difficulties ‘of a different kind’ and therefore saw his present situation as worse.

**Discussion**

The central finding of this study is the good outcome reported for twenty-three out of thirty-six cases, i.e. 64%. This must be compared with 70% for our previous study in 1994 and 62% reported by Burr (1993: the only other published statistically validated outcome study on solution-focused therapy at the time of writing) for thirty-four cases followed up in a child and adolescent service.

As in our previous study we found no significant variation in outcome for different social and occupational groups. This differs from published outcome studies of other ‘talking treatments’, all of which show greater benefit for those of higher socio-economic status. This is important for publicly funded healthcare systems which are more likely to serve relatively disadvantaged segments of the population. This effect is likely to increase if a developing private psychotherapy sector draws the more affluent members of society elsewhere. Therapies suited to those with limited resources of time, money and education are essential if equitable provision of services is to be made.

Our 1994 figures suggested that selecting goals which involved new activities predicted better goal achievement for most attenders. However, in this study it appears that useful goals may involve starting new activities or stopping old ones with equal benefit.

That longstanding problems are less likely to do well is common to most psychotherapies and is confirmed here. Our 1994 series found that longstanding cases did as well as short-term ones but were more likely to require advice later from other mental health professionals and to develop new problems after ending therapy.

Significantly fewer new problems arose for our ‘good outcome’ group. This confirms the experience of Burr (1993), who received only four reports of new problems in his twenty-six ‘good outcome’ cases. De Shazer’s results are similar (de Shazer, 1985). This contradicts the widely held belief among therapists trained in psychodynamic therapy, for example, that symptom substitution or relapse will occur unless ‘the real problem’ is uncovered by detective work.
on the part of the therapist. The concept of ‘flight into health’ (in which those recovering after only a few hours of therapy are held to be avoiding exploration of ‘the real problem’) is also challenged. ‘Other problems’ had improved in significantly more of our ‘good outcome’ group. This is found in our own and others’ outcome studies of brief therapy (Weakland et al., 1974; de Shazer, 1985). Echoing Burr’s (1993) finding that twenty-seven out of thirty-three attenders did not require further advice from other professionals, we found no significant difference between our ‘good outcome’ and the rest of the sample on this issue. These findings suggest that the resolution of one major difficulty enhances attenders’ power to deal with a range of other matters.

Combining our results over six years, ninety-five cases were referred for brief therapy, of which eighty-three were seen and seventy-seven contacted for follow-up information. Sixty-eight percent of these seventy-seven cases (270 individuals) reported a good outcome for an average of 3.5 sessions/referral (or 1.29 sessions/head).

The European Brief Therapy Association is co-ordinating the use of the questionnaires employed in this study in a number of potential research projects in various European countries. All those concerned hope to continue refining the process of solution-focused brief therapy in order to bring effective help in making changes to as many people as possible.

Acknowledgements

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References


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Appendix

Questionnaire to attenders

Dear ................................................

About a year ago you were referred to the Brief Therapy Clinic at .........................

We would like to know how you have been getting on. This may help us to help other people in the future. Your replies will be kept confidential.

1 Your goal when you saw us was to

........................................................................................................................................
........................................................................................................................................

Was this goal achieved? Yes/In part/No

2 Did you achieve any other goals at the same time? If so, please list these.

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........................................................................................................................................

3 Have any new problems appeared since we last saw you? If so, can you list them?

........................................................................................................................................
........................................................................................................................................

4 Has anyone in the family seen any mental health professional for advice since you stopped seeing the Brief Therapy Team? If so, please state which professions.

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........................................................................................................................................

5 Are there any comments you would like to add about your experience of Brief Therapy?

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Please telephone ...................... at ...................... if you would like help completing this questionnaire. Thank you for your assistance in returning the questionnaire. A stamped addressed envelope is enclosed.

Yours sincerely
Therapist
Brief Therapy Team
Questionnaire to general practitioners

Dear Dr......................................

BRIEF THERAPY TEAM FOLLOW-UP

About a year ago ........................... and ........................ were referred to the Brief Therapy Team. It is now a year since we have seen them and we are collecting follow-up information with the permission of the Ethical Committee. The goal they identified at the time of referral was

........................................................................................................................................

To your knowledge, have they achieved this goal?

Yes/In part/No

Are there any additional comments you would like to make?

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Thank you for your help.

Yours sincerely

Therapist

Brief Therapy Team