Use of solution-focused brief therapy to enhance therapeutic communication in patients with COPD

Steve Smith and Pamela Kirkpatrick put the case for a patient-centred framework for safe, effective care

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Abstract

Most people with chronic obstructive pulmonary disease (COPD) go undiagnosed and many of those who are diagnosed receive only symptomatic treatment. The difficulty of engaging patients with COPD in effective treatment plans is recognised, and healthcare professionals stress the importance of good communication. There is little in the literature to suggest how practitioners can provide this advanced, patient-centred care. The authors of this article argue that solution-focused brief therapy provides a framework for nurses to deliver safe, effective care that builds on 'what is well' with the patient and places their needs and agenda at the centre of care. They offer examples of techniques that can enhance practice, supported by case illustrations.

Keywords
Collaborative relationships, empowerment, goal setting, interactions, long-term conditions, solution-focused

ALMOST TWO thirds of people with chronic obstructive pulmonary disease (COPD) in the UK go undiagnosed (Healthcare Commission 2006). The British Lung Foundation (2007) argues that as many as 2.8 million people in the UK are unaware they have COPD. Care for the remaining one million patients diagnosed with COPD focuses on symptomatic treatment. The disease is often treated episodically and effective treatment depends on patient compliance and persistence (Fromer *et al* 2010).

Many people with COPD are reluctant to seek help because they blame themselves for their condition, leading to reduced self-care and autonomy (Robinson 2005), stigma (Gysels and Higginson 2008) and feelings of loneliness (Elofsson and Ohlen 2004). De Voogd *et al* (2009) found that depressive symptoms are associated with mortality in patients with COPD, independent of age, gender, 'Wpeak' – an individual's peak power output measured in watts – and smoking behaviour. Bailey *et al* (2008) note that patients' beliefs regarding the causes of their condition can lead to self-blame and reduce their compliance with treatment plans such as pulmonary rehabilitation and smoking cessation programmes.

The impact of COPD on people's quality of life is influenced by many factors, including degree of autonomy, knowledge and social circumstances. Healthcare professionals cannot know how these interact for each patient. Therefore, support for people with COPD needs to be collaborative to take account of the patient's situation (Kirkpatrick *et al* 2012), and the National Institute for Health and Care Excellence (NICE) guidelines on COPD emphasise the importance of patient-centred care: 'Good communication between healthcare professionals and patients is essential' (NICE 2010).

However, health professionals typically focus on their resources and those of other professionals, and do not always include in their treatment plans information based on opinions and resources regarded as useful from the patient's perspective (Yen *et al* 2011).

Despite the recognition that effective communication is central to the care of people with COPD, there is nothing in the literature on COPD to guide healthcare practitioners in delivering

Box 1 A miracle day

Patient: I would just be normal, like I used to be.
Nurse: What is that like?
Patient: I would be happy to wake up; I would feel ready for the day.
Nurse: What would you do?
Patient: I would go downstairs and get a cuppa.
Nurse: Tea? Coffee?
Patient: Oh, tea. I like a cup of tea first thing.
Nurse: Anything else?
Patient: Well, I would probably have a puff. I know I am not supposed to, but it helps settle me down in the morning.
Nurse: What else would you do?
Patient: I would have my breakfast.
Nurse: What would you have?
Patient: Toast and marmalade probably. That is what I usually have.
Nurse: So, who else would notice that something was different the day after this miracle? What would your husband notice?
Patient: He would see that I was more cheerful.
Nurse: How would he know that?
Patient: Well, I would maybe be singing. I used to do that a lot.

effective, individualised therapeutic communication. A broader view of the literature shows that one approach that appears to have promise is solution-focused brief therapy (SFBT) (De Shazer *et al* 1986, Smith *et al* 2011). This is an approach to communication that helps to evoke solutions, rather than explore problems. It is oriented towards outcomes and based on competencies, with future goals set by the patients (Macdonald 2011).

The approach asserts that most people have personal resources and positive experiences on which to draw, and thus they make sometimes small but important life changes (Macdonald 2011). People are valued as resilient and creative problem solvers, and rather than the nurse being the expert and the patient the seeker of a 'magic fix', they work together to construct solutions for positive change (O'Connell 2005). SFBT has earned a reputable following internationally in practice settings including psychology, education, physical and mental healthcare, counselling, and substance misuse (O'Connell 2007, Quick 2008). Most importantly, SFBT is also useful in structuring less formal interactions between healthcare professionals and patients and their families.

This article reviews the use of SFBT by analysing the significant factors in an SFBT conversation and links these to COPD-focused interventions. It relates the theoretical basis, historical emergence and practicalities of the use of SFBT by nurses supporting people with long-term conditions, particularly COPD, and evaluates its relevance and wider application in nursing practice.

Background

The roots of SFBT began in the Brief Family Therapy Centre, founded by Steve de Shazer and Insoo Kim Berg in Milwaukee in the US in the late 1970s. They noted that patients made progress by exploring their possible futures and felt empowered speaking about their desires (O'Connell 2007). As the future does not exist and must be 'imagined and invented', solutions are interactional and involve other people (O'Connell 2005).

De Shazer and colleagues were interested in, and placed great emphasis on, times when the problem was not happening; that is, episodes of time (pockets) when exceptions to (deviance from) the presenting problem were experienced then amplified and reinforced. The exploration and continuation of this 'non-problem' behaviour is central to SF practice. Quick termed this 'deviance amplification' (Quick 2008).

As SFBT developed, the inclusion of a 'miracle question' became central to the discussion: 'Suppose tonight, while you are asleep, a miracle happens, and these things are gone. You would not know about the miracle because you were sleeping. In the morning, when you wake up, what will tell you the miracle has happened?' (Macdonald 2011). The patient is encouraged to describe in detail what this 'miracle day' would look like. With SFBT and COPD, this description typically involves 'not being breathless' or a similar description of the absence of symptoms. However, clarification is then sought as to what the patient would experience instead of breathlessness. An example is given in Box 1.

In the example, the nurse does not challenge the patient's assertion that smoking helps her 'feel better'. Meek (2005) notes that the emic, or personal, nature of the patient's emotions and symptoms makes it difficult for nurses to empathise accurately with patients' experiences; rather, the nurse continues to search for what would be different the day after this miracle.

In this way, SFBT is pragmatic rather than theoretical, adopting Occam's maxim that 'it is vain to do with more what can be achieved with less' (De Shazer and Dolan 2007, O'Connell 2007). Future hopes are constructed from present resources through the creation of a desired vision (O'Connell 2005, McAllister 2007). De Shazer and colleagues conclude that the practitioner need not know the cause of the problem or how it is maintained; what is required is that the person 'does something different' to break the cycle (Quick 2008). This can be achieved through the adoption of a 'not knowing' position in which the patient is placed in the position of 'expert'.

In the extract of a conversation in Box 2, John (not his real name) is a 69-year-old man with moderate COPD. He has recently commenced pulmonary rehabilitation, although he has not attended his second meeting.

Here, the nurse begins by taking a 'not knowing' stance in relation to John's lack of attendance at the second rehabilitation meeting. This allows John a sense of agency over how he tells his story of non-attendance. This is especially relevant in the treatment of COPD where a sense of agency can help to control against anxiety, resulting in respiratory failure leading to hospitalisation (Bailey *et al* 2004). The nurse avoids censuring him or providing information about why he may have felt unwell, and simply accepts – for the moment – John's position.

When a challenge is offered to this position, it also comes from a not-knowing stance in which the nurse asks John to explain to her how this represents a positive choice for him. When he cannot do this, the nurse takes an opportunity to encourage John to explore his resources further. Only at the end of the conversation does the nurse do anything except ask questions – even the offer of help is phrased as a question.

Box 2 Conversation with a patient

Nurse:	So, how are you getting on at the pulmonary rehab?
John:	I don't like it. It gets me down.
Nurse:	Oh, how come?
John:	I went along to the exercise group the last time, and it was full of old folk a lot worse than me. The exercises made me feel ill. I got so breathless, I wasn't right for about two days afterwards. So I did not go back.
Nurse:	Oh, okay. So… what do you think will help?
John:	I don't know. I have got my inhaler; that will do for me.
Nurse:	Oh right, okay… but I am confused. Wasn't that what you were doing before, and you were using the inhaler more and more?
John:	Yeah, well, I was, but I am not going back.
Nurse:	Okay. So what could you do that would help? What could you do that would not make you ill for two days?
John:	I don't know. Maybe if I did something a bit lighter? Something around the house, maybe?
Nurse:	Would that help?
John:	It might be better than going to the rehab centre.
Nurse:	Hmm… might be. Have you got any self-help stuff that you could do in the house?
John:	No.
Nurse:	That is a shame. It was a good idea, too. Do you think that if I spoke to someone about getting some stuff, it might be helpful?
John:	I suppose it might be.
Nurse:	Okay, I will see what I can do.

Principles for practice

SFBT considers individuals to be skilled, imaginative and resilient problem-solvers. Practitioners place an emphasis on building capacity by finding out 'what works' for a person and encouraging them to 'do more of it' (O'Connell 2007). The philosophical message conveyed to the person is that 'there's nothing wrong with you that what's right with you can't fix' (De Shazer and Dolan 2007). Thus, SFBT is guided by several underpinning principles (Burns 2005, O'Connell 2005):

'If it is not broken, do not fix it' This principle recognises that people with health problems are also host to a range of strengths and abilities that enable them to function in the midst of difficult circumstances. It is important that nurses recognise what is working for the patient, and only attempt to change what is problematic.

'Small changes can lead to bigger changes' It is often easier and more acceptable to patients to try to bring about a small change that 'moves things' in the direction of a solution, rather than to try to bring about a large change that will solve everything. Systemic thinking illustrates that a small change in one part of a person's life can bring about larger changes in time.

'If it is working, keep doing it' It is often important to highlight or amplify to patients the success they have achieved, and to reinforce that further success can be anticipated if they continue to do more of what they have started.

'If it is not working, stop doing it' The often-overlooked concomitant of the above principle is to highlight existing behaviours or changed behaviours that are not helping. Questions such as 'Does that help?' are useful in allowing patients to identify when something is not working, even though they might have expected it to.

'Keep therapy as simple as possible' The goal of successful interactions is to 'keep on message' and not to be distracted by red herrings in the conversation. In the example conversation in Box 1, the references to cigarette smoking could easily have diverted the conversation into a familiar cycle of health education and denial, rather than helping the patient to develop a positive vision of his future.

Techniques for practice

These principles or philosophies are crucial to the relationship and form the foundation for the communication required in a standard SFBT conversation. The first meeting is often when the

Box 3 Scaling

Nurse: So, where are you on the scale today?
May: At a seven today, because my breathlessness has reduced since last week.
Nurse: Brilliant. How did you manage that?
May: I do not know. I just seem to be breathing a bit better.
Nurse: Well done you. What else have you been doing to get up to seven?
May: I have been using the wheelchair when we go out, rather than trying to walk everywhere. I think that walking makes me more breathless. I let Bill push me, and that way we get out more.
Nurse: Excellent idea, well done. So… how will you know when you have got half a point higher – say 7½ or even eight?
May: I would be less breathless and reducing my steroids.
Nurse: Okay. What would be enough of a reduction to know you were at 7½?
May: Maybe if the doctor put me back on the smaller dose I was on before this last time.
Nurse: So being on the smaller dose will let you know when you are at 7½? What would let Bill know you were at 7½?
May: He would have to do less to help me and he would see that I was more content in myself.
Nurse: Where on the scale is 'good enough' for you?
May: I think I would be happy with eight.
Nurse: How confident are you, on the same scale? How confident are you that you will reach eight?
May: I would say about a nine.
Nurse: Excellent; so first 7½ and then on to eight. Brilliant.

most work is achieved. It begins with conversation about topics other than the patient's problems, enabling engagement in purposeful conversation and helping to build a connection with the patient. It assists in the search for strengths and resources, illuminating competence at every opportunity (Burns 2005, Macdonald 2011). However, building the relationship through respect, empathy, acceptance and listening is more important than specific SFBT techniques (O'Connell 2005) – it creates an environment conducive to change by forming collaborative relationships, clarifying goals, highlighting resources and negotiating tasks (O'Connell 2005).

The conversation is characterised by several typical steps:

Recent change De Shazer *et al* (1986) noted that patients experience positive changes between making an appointment for a meeting and the meeting itself (Quick 2008). Similarly, in conversations between patients and nurses about solutions, if change has occurred – and it does in over 60 per cent of cases – this is highlighted and amplified: 'Wow, that is excellent. How did you manage that?'

This can be empowering, demonstrating resources and the ability to find solutions independent of the nurse. Patients must put their hopes in their own words, which makes their perception of the problem and its solution central to the conversation (Burns 2005). Individuals are encouraged to set clear, specific and small but realistic goals (Cepeda and Davenport 2006). Having a measure of what success would look like is useful. A clear goal helps both parties know the point at which the problem has been solved (De Shazer *et al* 1986). Classic questions to help develop this goal are: 'How will you know our discussions have been useful?' (Burns 2005) and 'What will be the first signs that things are improving?' (O'Connell 2005).

Miracle question The miracle question helps people develop their appetite for exploring change. The question should be asked slowly and gently, with the nurse pausing to allow the patient to enter the world of the 'miracle' and provide time to create the future image. It is intended that the patient articulate a view of a preferred future, without the perceived problem, and explain how it happened (O'Connell 2005). This helps patients to reframe their views of their lives and, through a detailed description, create desired outcomes from which they can work back to see how they can reach them.

Questioning related to the miracle – for example, 'What would you notice that was different?' – clarifies available strategies. As the nurse explores the patient's miracle responses, he or she notes exceptions where small pieces of the miracle may have already occurred (O'Connell 2007). If the patient responds with 'I don't know', the nurse should not move or speak, to provide the patient with some 'thinking time'.

Exceptions Searching for exceptions is crucial for finding 'micro solutions' to the patient's issues by helping to draw attention to times when the issue was better managed or happened less. Highlighting and exploring exceptions shows that they are not a fluke or unique and can happen again (Burns 2005). Iveson (2002) argues that no matter how significant the problem, finding exceptions is central to finding solutions. Highs and lows are typical in most people's lives and exceptions can reveal strategies for coping with setbacks or ongoing difficulties (Burns 2005). By asking questions such as 'How have you managed to do that?', 'What do other people notice that is different about you during this time?' or 'What else is better during this time?', the nurse can mine for details about the exceptions (De Shazer *et al* 1986, Burns 2005). Giving attention to exceptions 'sows the seeds of solutions', encouraging patients to create alternative

futures (O'Connell 2005). It helps them to develop and rehearse stories about solutions rather than enable them to continue to tell well-practised stories about problems, keeping with the notion that a positive future is created in words. As O'Connell (2005) states, 'exceptions are gateways to a new life story' and provide a foundation for building on what is working, such as medication concordance.

Scaling A useful way for clarifying communication, measuring progress and setting small goals is through scaling. Scaling is also effective in measuring motivation and confidence, which are both difficult to describe in words. On a scale of one to 10, with one being the worst ever and 10 being the best, patients place their current, past and future levels of confidence, motivation or progress (De Shazer *et al* 1986, O'Connell 2005, O'Connell 2007). The nurse must ensure the patient's judgement generates the point on the scale and must not influence it at all.

Scaling links with the notion that small changes lead to larger change and highlighting one small step up the scale, or indeed maintaining a position, helps to highlight positive perspectives of change and competence in coping. It is important that patients can look back from where they are and work out what they did that helped them to get to or stay at that number, despite their problems. They can also look forward and consider, with supportive questioning, what positive changes will bring (Macdonald 2011). It is crucial the nurse helps build a picture of competence and expectation that points further up the scale will be reached (Box 3).

Feedback At the end of the conversation, feeding back to patients about their positive achievements and 'what works' is a helpful reinforcement and should be linked to goals where possible. A bridging link is made to the task – essentially, this encourages the patient to keep doing what works, as elicited during the discussion. It need not involve the well thought-out specific task as deemed appropriate by the nurse but may be a simple 'noticing' task – for example, times when the problem is not so bad or perhaps when they feel good or do something they value (O'Connell 2007) (Box 4).

Box 4 Feedback

Nurse: You know, I am impressed that you have done so much since last week – that you have been using the wheelchair when you go out, and you have figured out that that's helpful and how it helps you be less breathless. That is great and it has helped you get up to seven on that scale. I would not be surprised if your steroids get reduced soon.

May: I hope so. I know that I just need to be sensible and take one day at a time.

Nurse: Absolutely. And because you are already doing so much that is working, I do not think there is anything else I need to tell you.

May: No?

Nurse: No. What I want you to do is notice all the times between now and when we next speak together that you get to 7½, or even get to eight, and make a note of that so we can talk about it again next time. Can you do that?

May: Yes, I think so.

Critique

Despite the positive outcomes and being patient-centred, several criticisms have been cited against SFBT, including that it is a cookbook approach, with a technique that is used insensitively, and that it is overly simplistic (O'Connell 2007). However, it may be that patients who have long-term conditions and are in crisis cannot access their personal resources, or that they want the nurse to provide solutions. Certainly, for people who are more concrete thinkers, this approach could be challenging because of the abstract nature of the miracle question. However, the scaling questions can enable people who find it hard to imagine a positive future to still measure their progress towards their goal. SFBT is intuitive and easily understood, making it accessible to various practitioners and contexts (Bowles *et al* 2001).

Solution-focused brief therapy and nursing

SFBT offers a framework for facilitating solution-focused conversations between healthcare professionals, patients, families and carers. Effective communication is a fundamental aspect of nursing, given the challenges nurses routinely face (McAllister 2007), and it is particularly relevant in the care of people with COPD (NICE 2010). The ethos of SFBT matches important nursing values, including the empowerment of patients, autonomy, self-care and self-management (Hillyer 1996). No great leap of imagination is needed to integrate SFBT into the nursing of people with COPD. It is culturally compatible with nursing, as its focus is on health and wellness rather than pathology, and it is geared towards extending individual strengths and resources (Bowles *et al* 2001).

The miracle question invites discussions about what patients want to happen, what they are doing to make them happen and what tells them that change is possible, and is an appropriate way of discussing lifestyle changes with patients recovering from an exacerbation of COPD, developing self-management skills or coming to terms with their diagnoses. Through conversations focused on

developing solutions, patients can be helped to adapt and live with their conditions and symptoms, no matter how bad things are (McAllister 2007).

Few nurses have time to develop non-directive relationships. However, a view of nursing as a practical, task-oriented profession, with emphasis on communication as a way of providing information, would seem to limit communication. In addition, the emotional cost to the nurse must be considered – many nurses avoid close emotional engagement, reducing their exposure to stressful and damaging situations (Bowles *et al* 2001).

Adopting SFBT in adult nursing contexts such as COPD care can help enhance patient-centredness, develop an empowering approach to nursing care and enhance patient support (Smith *et al* 2011). Further research is required to open up an exploration of the impact this low-key but intrinsically nurse-based intervention can have on the lives of people living with COPD, their families and the nurses who work with them.

Conclusion

SFBT is a forward-looking, minimalist way of helping people with COPD help themselves. It enables nurses and patients to share a collaborative relationship that helps focus on strengths and resources for achieving positive change. SFBT provides a framework for healthcare practitioners to work with people with COPD to construct and test potential positive futures, increasing the likelihood patients will adhere to care plans.

The significant factors in the typical solution-focused interview include setting goals, the 'miracle question', scaling and positive encouragement. Building a collaborative relationship is acknowledged as being as important as the technical aspects of the interview and is central to the effective treatment of COPD. SFBT provides nurses with a framework to achieve this, and the authors argue that it is a congruent intervention in the treatment of COPD the full potential of which is yet to be realised.

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Conflict of interest
None declared

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