

Practitioner Report

Using Solution-focused Therapy During a Psychotic Crisis: A Case Study

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During an assessment for therapy, one patient on an acute psychiatric ward proved to be extremely difficult to interview. He believed that demons were about to visit him, and this made conversation on the topic near impossible at first. Investigation of his beliefs resulted in him getting angry. At a later date, however, he requested meeting the first author. It was then decided to try out solution-focused therapy. Given this new start, it was then possible to begin systematic assessment of beliefs and emotional state. Over 6 months a fluctuating pattern of change emerged. Follow-up over 2 years suggested maintenance and considerable re-engagement with everyday activities. Beliefs were modified yet he retained notions of possible judgement by demonic forces. Copyright © 2002 John Wiley & Sons, Ltd.

INTRODUCTION

This paper will describe how a version of solution-focused therapy (SFT) (de Shazer 1988; Furman & Ahola 1992; Miller, Hubble, & Duncan 1996; O'Hanlon & Weiner-Davis, 1989; White & Epston, 1990) was used with a client diagnosed as having 'paranoid schizophrenia'. We will assume a continuum of thinking and techniques between SFT and approaches described as narrative: this position is also adopted by Eron and Lund (1996). SFT involves highlighting solution talk and includes: (1) a prolonged discussion of exceptions to problem patterns, 'what works' and imagined future solutions; (2) a focus on goals, small steps, and how a person would know these are being achieved; (3) building a collaborative relationship including careful attention to a person's language and

beliefs so that interventions fit with the patient's world view.

Typically, therapy does not proceed by isolated one-off questions, but by a sequence of questions fully exploring an area. (Lipchik, 1988). If an exception is mentioned, for example, a 'voice' was not heard when it usually is, then therapists might ask:

'What is different about those times?'
'What do you think you did differently?'
'What do you think they (i.e. others known to the patient) see you doing differently?'
'What has to happen for more of that to happen?'

(The above are quoted from Lipchik, 1988).

The thread of ideas is pursued wherever possible: to how others may be involved, to social context, to activities the person carries out, to meanings. A similar elaboration of ideas can be performed where appropriate, for goals, resources and strengths.

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After a session-break, such ideas are fed back to the patient, beginning with an explicit focus on relevant resources and strengths of the patient.

The approach described here is essentially derived from de Shazer (1988): we do not have space to describe the full range of ideas found in White and Epston's approach. We have borrowed from the latter the specific ideas of using letters as a form of therapeutic communication, and the general emphasis of how people may hold a 'narrative' about their lives which has crucial effects upon those lives. Furthermore, that narratives can become blocked, 'problem-saturated' or destructive and that a feature of work may be to help someone develop a more benign and optimistic narration (see also Sluzki, 1992).

SFT IN CONTRAST TO CBT

It is illuminating to contrast SFT with cognitive behavioural therapy (CBT). There are, of course, many types of CBT but common to all is the assumption that in order to solve a problem a careful assessment of difficulties needs to be carried out: the aim of this is to generate a 'formulation' which typically involves a causal explanation. Some emphasize a 'functional analysis', for example, Yusupoff, & Tarrrier, (1996) in his 'coping enhancement strategy' (CES) suggests analysing the antecedents of a symptom. If a person's hallucinations increase in stressful situations, then an intervention aims at altering the antecedents. The diverse writers of CBT tend to emphasize different aspects, so, for example, Beck has emphasized the content of beliefs (Beck, Rush, Shaw, & Emery, 1979).

In sharp contrasts to the above, SFT does not use 'assessment' to generate a formulation, nor does it claim that a causal formulation leads to a choice of interventions. At its most extreme, some reject the possibility of objective truth or scientific generalization (de Shazer, 1994): hence, one might design an intervention for a client that 'works', but not know why nor how, nor assume it could be reproduced with another client. A less extreme epistemological position, and one we adopt here, is that previous generalizations may not fit a particular case, and in working with a case we cannot be certain why something works. Given this framework, SFT tends to emphasize a person's discourse and reported experience: ideally 'interventions', emerge from a person's experience and language and remain in that language. In

doing SFT, there is a strong tendency not to introduce concepts such as 'education', 'training', or 'socialization' into a model.

An idea suggested in therapy, for example, 'go for a walk' might appear to be the same as in CBT, but crucially this would have been first suggested by the patient and thus the contextual meanings of the 'task' are different. Furthermore, in some types of SFT the task will be carefully linked to wider meanings, so 'going for a walk' might form part of 'reclaiming one's life', that is, of a wider narrative (White & Epston, 1990). In CBT, the task is assumed to arise from expert knowledge, that is, previous research into how types of task affect types of difficulty.

SFT tends not to move through a strict series of steps in a strict order, though naturally some questions are used more at the beginning than elsewhere, such as a description of the problem and goals. Rather, according to the client's presentation, SFT moves back and forth between the areas of exceptions, knowing, goal, the future imagined solutions, whilst continuing to build a narrative less dominated by the 'problem-saturated story' (White & Epston, 1990).

We have here emphasized the differences and unique aspects of SFT: however, we are not claiming one therapy to be superior to another and do in fact use both in practice. Given a critical realist view of science (Held, 1996; Pilgrim 2000), that is, that there is an external reality and at least the possibility of 'truths', even if we can never be sure, then it seems possible to make the two therapies complementary.

SYSTEMIC THERAPY AND PSYCHOSIS

There is a long tradition in systemic therapy of working with psychosis (Batson, Jackson, Haley, & Weakland, 1956; Selvini-Palazzoli, Boscolo, Cecchin, & Prata, 1978). The development of ideas in this area is reviewed by Evans (1997), and a more recent illustration of SFT with a range of long-term psychiatric difficulties is given by Rowan and O' Hanlon (1998).

Work with psychosis is briefly illustrated in de Shazer (1988) and family work for schizophrenia by White (1989). de Shazer discusses the case of a man who believed the CIA were planning to kill him but who also presented with a range of problems. Eventually de Shazer expressed puzzlement as to why they (i.e. the CIA) had not yet succeeded: crucially, de Shazer stated he did not wait for

answers or elaboration but moved on to other concerns of the client. After this the topic was mentioned less and less and de Shazer was then able to focus on the man's difficult relationship with his wife. Detailed casework illustration is also described by de Shazer (1994).

There has of yet, been little research into the effectivity of SFT for types of difficulty, nor into the processes involved (for a summary see McKeel, 1996). The findings given suggest it may be at least as effective as other therapies (MacDonald, 1997; McKeel, 1996; Gingerich & Eisengart, 2000).

CASE STUDY

How Therapy Began

Jim (all identifying features are altered) was first seen as an inpatient in a psychiatric ward during the Spring of 1995. This case began with the intention of carrying out a detailed assessment, followed by cognitive-behavioural therapy as part of an ongoing therapy trial conducted by the authors. The attempt to place Jim in the trial had to be abandoned: in an early meeting with Jim, he informed the first author that he could afford '10 min only'. Jim spent literally all day on the ward reading books out loud since he believed two demons were about to judge him on his reading. If he got his reading wrong, he would immediately go to hell. Subsequent appointments were offered, and were either missed or were too difficult to proceed with. By the end of summer, however, Jim asked to be seen again. At this point it was decided to use SFT, i.e. we would try to work briefly within his framework or phenomenology to find some 'solution' or small step to relieve his painful experiences and to help calm the continuing crisis as quickly as possible.

It is difficult to see how a conventional CBT type of assessment could have been carried out in these circumstances. The coping enhancement strategy (CES) of Yusupoff, & Tarrier, (1996) suggests several straightforward practical techniques, but he too states that 'the CES approach relies on eliciting a detailed account of the components of the emotional reaction and their reciprocal relationship' (p. 88). If one simply gives out suggestions, e.g. relaxation, then there is nothing specifically CBT about this. One alternative might have been a model of problem-solving (Hawton, & Kirk, 1989): practical as these clearly are, we believe that SFT offers very creative new ideas in this area, especially for problems which in themselves

are difficult to even conceptualize. Problem-solving often relies on 'brain-storming', but it is not clear what to do if no ideas are forthcoming. In contrast, SFT has a range of tasks for generating new ideas, for example, 'notice what you do when you overcome the urge to do X', or 'please note what you want to continue about your present life, relationships, etc' (de Shazer, 1988).

Client Profile

Jim, at the time of beginning regular sessions was just 24 years of age. He was generally well liked and he could be described as talkative and friendly. His childhood was reported to be unremarkable. He described his teenage years though as a series of incidents in which he got into trouble with the police, engaged in multiple drug taking, petty crime, and frequented clubs. In his early twenties both parents died within a year of each other. Within 2 years, one sister died and another became a missing person. He explained how he had tried to look after his three sisters, yet this had proved impossible. Towards the end of 1994 he began to break down and was eventually hospitalized. He was placed in a hostel, yet he was hospitalized again within weeks due to his extreme behaviour, i.e. he was reading out loud for several hours per day and in general showed that he was terrified. He was diagnosed by the psychiatrist as having paranoid schizophrenia and placed on phenothiazine medication. In spite of the latter, the delusions continued and when placed back in a hostel, he was still terrified of demons arriving and continued reading, though now reduced to a few hours.

Assessment Methods

The standard assessments we hoped to use during our research included the Beck Depression Inventory (BDI), the Beck Anxiety Inventory (BAI), and three scales borrowed from cognitive therapy (Chadwick, Birchwood, & Trower, 1996; Fowler, Garety, & Kuipers, 1995). Each scale has five statements ranging from 'not at all' to 'absolutely': the scales examine degree of conviction, pre-occupation and distress concerning the main problematic belief or delusion. Because of Jim's behaviour, for a time the above were not used: however, as he calmed down they were re-introduced without difficulty. Most SF therapists do not use psychometrics, and the focus of questions on problems is seen as potentially a block to successful SF

work. However, this does not appear to be the case here, and the scales all had a positive end-point.

First Phase of Therapy: Coping with the Crisis

When Jim arrived for the first SFT session, the problem was already well known: from direct observation on the ward and written reports. Furthermore, we were a few weeks from his birthday when he was sure of an attack. The aim of the first phase was to find some way of coping. When he stated bluntly to me that this time he would die I asked him 'what can you do?' He replied 'have a party ... keep my mind occupied. Be around people'.

This question and answer illustrates how sometimes clients will make suggestions in spite of pessimism and ideas which on the surface appear almost 'illogical', that is, how could a party stop demons? In designing client-specific interventions, one must sometimes accept answers which seem surprising and counter-intuitive. For this patient, having a 'party' is considered to be protective against death and 'demonic' attack: if such an idea 'works' there is no way of being sure of how any psychological mechanisms played a role. CBT tends to have little to say about such situations, whereas in SFT it is both accepted and used.

He went on to mention how the demons had said they would come the year before but had not. Before this interesting potential 'exception' could be explored, he asked if I was judging him. I simply replied 'no', that I thought he was 'OK' and had been through a lot. This answer was both true from my point of view, but also illustrates how opportunities for a focusing on strengths can emerge at any time. A more problem-focused approach could have opened up the topic of why he asked such a question. We doubt such a response, at this stage, would have helped with the crisis.

We returned again to coping: I asked 'what makes you feel safe?' This proved to be a useful way of exploring exceptions to the problem; fortunately, times of feeling safe were linked to actions he could do deliberately. On this first occasion he mentioned being around people, reading, pray, and watching TV. I returned to this question several times and he added details such as listening to the radio at night, leaving his door open a little during the night so light could enter from the corridor. An important feature of the second and third session was the presence of a member of staff from the hostel where Jim had returned to in the autumn. They took note of the various activities that helped

make Jim feel safe and said they would emphasize these with all staff working with Jim. Further work was discussed with staff over the telephone during the period of therapy.

Before ending the session, we returned briefly to his comment that a visit by demons had been promised last year but failed to happen. At this point I asked the question, 'I wonder if they're about to con you?' This failure of a 'promise' might be construed as a type of exception, that is, he expected the problem to occur but it had not. From his exact words his attitude seemed unclear, but they were taken to imply the possibility of doubt. To open up this topic was not part of a therapy plan: one strength of SFT is that it emphasizes improvisation following the direction of patients. He doubted the suggestion I made: however, the idea of being 'conned' or its possibility seemed plausible to Jim. It 'fitted' his world view. This theme was returned to many times in the second and subsequent sessions: according to the 'global frame' (de Shazer, 1988) of Jim, the demons should have arrived. Using a neutral language which did not commit me to any belief concerning demons, I was able to express puzzlement that they had not arrived as predicted in the past: he was certain they would arrive this time. From this point I was able to ask such questions as: if demons are demons, then surely they would lie and bluff people as bullies do? Furthermore, 'as you stated', is it not God's business to judge and decide who dies and when? Jim always listened to such questions with intense seriousness, usually answering that he simply did not know. Sometimes he would finish by saying 'yes ... but ... this time I am sure'. In the fourth session I asked him: 'how will you know when they really are gone?' He declared 'They've got to appear first!' I continued, but if they do not come, how long? He stated that after 2 months he would be 'OK', would have 'serious doubt' and after 1 1/2 years would forget it.

Another focus in the first few sessions was his description of important goals for the future. In the first session I asked briefly what his goals were: they included winning the Lottery, going to college, holidays, clothes, having a career, children and a wife. When asked the 'Miracle Question' (i.e. where a person is asked to describe a life without the problem) he stated a similar list of things. On a scaling question where 10 was this future better life, he was at '6'. I asked what a next step might be and he answered '...to unbuckle my feelings' and he would begin 'doubting the demons'. I asked how he might do that. He said he would do that

by changing his 'way of thinking' and seeing if the demons were 'that powerful'. I asked what might give him strength to do that: he said he was trying 'to keep thinking positive' and was trying to 'remember decisions', i.e. to give up drugs and lead what he saw as a better life.

As the work progressed each session provided opportunities for exploring further exceptions. One major exception continued to be the fact that there had been no 'visit': this provided occasions when 'demons' as 'liars' could be elaborated. Another exception was that on one occasion he said he had not thought of demons for 5% of the time. The occasion had been when he had discussed going to college with a worker from the hostel. On other occasions he had heard strange 'hissing' sounds, but had switched on the radio and used other safety ideas as planned.

Second Phase: Consolidation

By the fourth meeting Jim was developing doubt concerning an immediate attack, and generally was less fearful. He did not, however, simply recover: rather, during the next six sessions was a period of periodic 'see-sawing', in and out of extreme fear followed by several sessions where these changes became less dramatic. All the themes and questions of the first phase were returned to again and again, i.e. what were his goals? What made him safe? There had been 'promises' before of attacks, so why believe this time? How long before all this was behind him? As he began to move out of his fears, we talked about what steps he could next take. I asked how he could 'reclaim his life?' Often this involved taking small steps such as going swimming.

It could be argued that when we first met Jim he seemed to be stuck in a fixed 'moment' that repeated itself: that is, he always seemed to be 'about to be attacked'. A development now was to continually emphasize that some things might be behind him, and new things ahead, that is, we were attempting to rebuild a narrative sense of time and change.

Just before the Christmas break I thought it might be useful for Jim to have a letter summarizing much of what we had said, particularly how he had survived, key notions about demons, and actions he might take. The letter emphasizes how some things are now past and the future lies open. The use of letters was influenced by the practice of White and Epston (1990): the letter in full is given in Appendix A.

For 2 weeks a 'prediction task' was used. He was asked to fill in a form each night on which he had to predict whether the next day would be one where 'God is in charge' or 'the demons are in charge': these were the exact phrases Jim had employed. He only predicted the demons once, and did think about them during that day. This is a task sometimes used in SFT (de Shazer, 1988): our hope in suggesting this was to bring Jim's attention to what he regarded as positive days and yet also give some sense of being able to anticipate and plan for negative days. If anticipation did in fact start a negative series of events, his preparation might then change direction.

As work progressed other aspects of the problem of narrative or 'time' emerged: he claimed to be sometimes experiencing *déjà vu* when walking the street, and that on one occasion he had seen his future life. I wondered again whether this was 'misinformation' since most Christians do not believe the future can be predicted. He decided he would defy these feelings by walking outside regardless of what he experienced. Again, it is noteworthy how this conception of his future as already in some sense 'fixed' almost came to block him taking action. Here a narrative focus involved discussing how some people thought the future unknowable and not determined, and hence there was hope for change.

Third Phase: Moving On

From the 14th session onwards his levels of concern seemed to fall again, and on the 16th his conviction even dropped to 0%, although it returned. There seemed clear evidence that his mental state had altered and might have stabilized. It was decided to enter the last phase of regular sessions. The majority of work in this phase continued as before, but with a greater emphasis on making decisions about his near and not-so-near future. He now started planning for the latter half of 1996 when he hoped to take the bigger steps of taking a course at college and getting his own flat; furthermore he became interested in doing voluntary work. Eventually he reported great satisfaction with his voluntary work helping in a centre for the homeless: this of course provided a good opportunity for positive feedback and exploration of the strengths he possessed.

During the last few regular sessions and during follow-up appointments there was no systemic attempts to trace out his life-history, yet it was striking how he could now address his past and begin to trace out a clearer narrative of key

traumatic events. That is, we began to build a richer narrative from parts and fragments as they occurred to Jim.

In one session he told me that sometimes he thought he had put his father into an 'early grave' by his difficult teenage behaviour. Such questions were an opportunity to remind him of other ideas in his Christian faith, for example, the time of death was not decided by other humans, but his God. We could also discuss contextual aspects such that his father had had medical difficulties due to diabetes.

One curious feature of this case is that Jim on one occasion presented the therapist with a letter stating that it was only to be opened if he suddenly died. Two years later we looked at it together: essentially it was strange account of events he believed to have occurred during his young years, much of which involved death and violence committed by him. The events are fantastical and could not have occurred. This act by him, not at our suggestion, was also a form of narrative.

Eventually sessions were many months apart. Each session usually involved a review of progress and a discussion of any new concerns which had emerged. At one phase his level of anxiety had increased: however a review of the central ideas of 'what worked' seemed to help. Particularly useful was the reminder of how far he had come and how he had survived the worse.

What gave Jim the strength to continually make these changes? This of course can only be speculation: the therapy concentrated on several details almost simultaneously, and any or all might have made the significant difference. That stated, from his discourse within the sessions, the 'turning' points seemed to be ones where he made a 'decision' to resist, the realization that there was something he could actually do about the situation, coupled to a fluctuating hope that the 'attacks' were over if not based on misinformation in the first place. These gave him the strength to then confront his fears. As the situation changed, he was able to widen his perspective, remember more details and thus engage in developing new meaning.

Outcome

At the beginning of most sessions Jim was asked to rate his percentage conviction in the following written statement: 'The demons will come to test me on what I am reading. If I get it wrong, I'll go to hell; if right, I'll go to heaven'. A simple statement about the existence of demons was not used since it was assumed that he would not tolerate this question even being raised.

Within three sessions of SFT Jim's conviction in this statement began to decrease (see Figure 1); over several weeks Jim then seemed to see-saw between

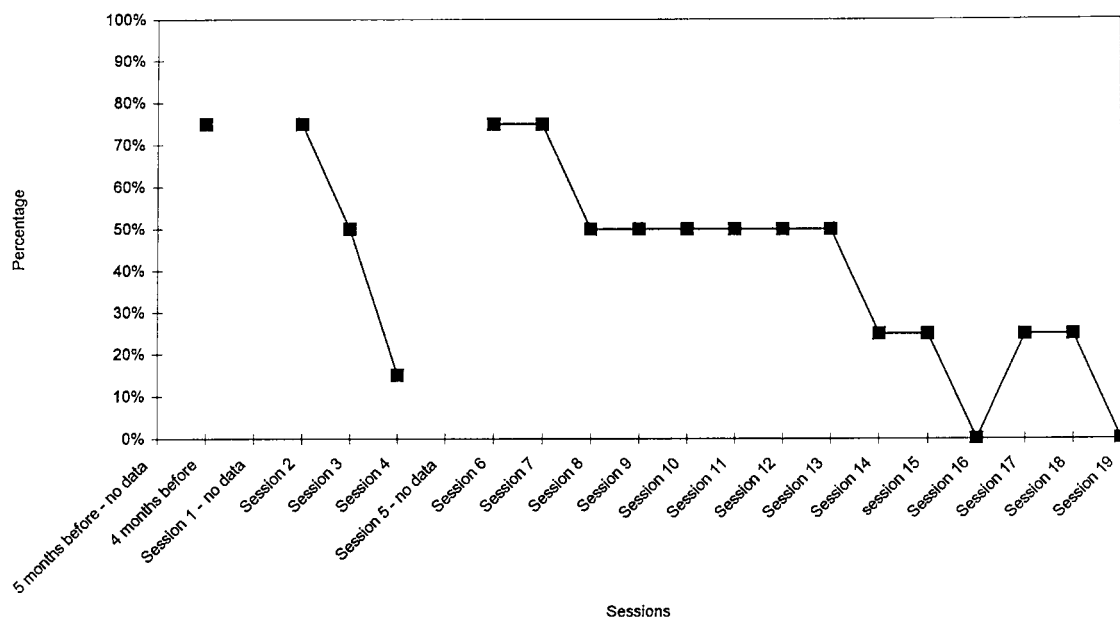


Figure 1. Percentage conviction during therapy

uncertainty and the merest hint of confidence. When the initial phase was finished, Jim was seen monthly, then at intervals of several months. Over the 2 years of follow-up his conviction rates became stable, although with occasional episodes of doubt.

There is a similar pattern for change in anxiety concerning demons, i.e. an initial fall-off, then a very long phase of see-sawing until a more stable lower level is established. During the follow-up period the level fell yet again. The pattern for ratings of preoccupation with his belief during the therapy phase was of drastic variation; however, the eventual result seems to be that he rarely thought of demons, although with occasional powerful returns (see Figure 2).

The Beck Depression Inventory and Anxiety scores show clear patterns of reduction from high

levels of depressive and anxious symptomatology to subclinical level (see Table 1), i.e. a score above 10 on the BDI suggests mild clinical depression and above 10 on the BAI suggests clinical anxiety.

Table 1. Beck anxiety and depression scores during active therapy

Phase	Date	BAI	BDI
Before therapy	June 1995	19	20
During therapy	Nov 1995	27	29
During therapy	March 1996	17	22
During therapy	May 1996	22	12
During therapy	June 1996	3	6

For the BDI and BAI 0 to 9 indicates absence of depressive or anxious symptoms, 10 to 18, mild to moderate and 19 to 28, moderate to high depressive/anxious symptoms.

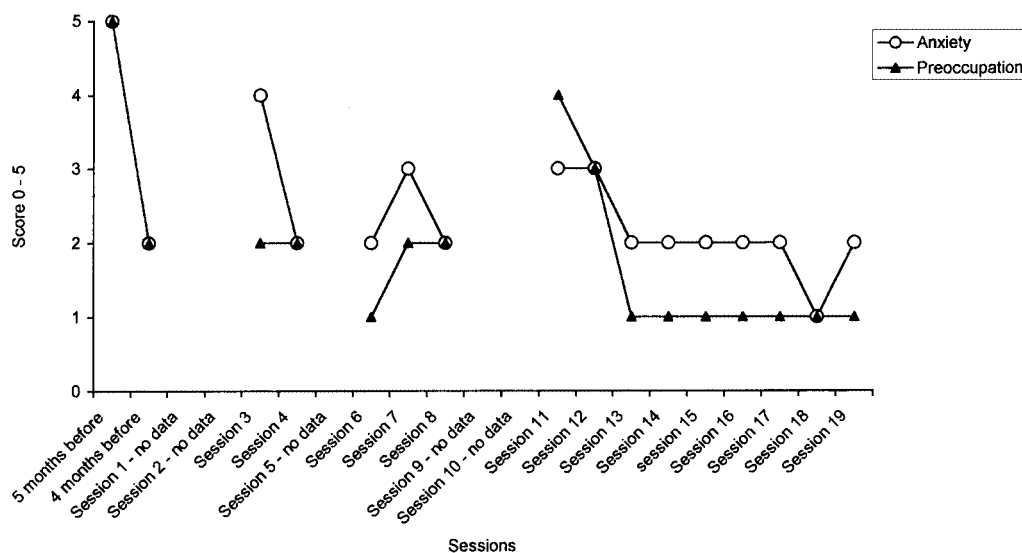


Figure 2. Anxiety and preoccupation during therapy

Table 2. Two-year follow-up data

	DEC 1996	APR 1997	JAN 1998	MAR 1998	JUN 1998
BAI	12	3	—	5	7
BDI	9	2	—	5	4
% CONV	25%	0%	10%	50%	25%
PRE-OCC	1	2	—	2	2
ANX	1	1	—	2	2

BAI = Beck Anxiety Inventory; BDI = Beck Depression Inventory; %CONV = Percentage Conviction; PRE-OCC = Preoccupation; ANX = Anxiety.

Over the last 2 years of follow-ups Jim made enormous changes in his life and maintained low levels of symptoms (see Table 2); he eventually left the hostel for his own flat and in autumn 1997 began a course at college, although he stopped this when he felt 'too stressed'. He continued being actively involved in voluntary work. He did not return to street drugs nor excessive drinking. He continued to believe in the existence of 'demons', yet he began to see these in more traditional terms of Christian belief.

DISCUSSION

The results show a substantial fall-off in aspects of Jim's delusional beliefs. A weakness of the design was the very short baseline: hospital and community staff observations suggest, however, that he had been talking about demons and acting as though he believed in his ideas for at least 1 year before therapy. He reported, in fact, seeing 'demons' on some occasions during his teenage years. What factors could account for the change? Medication is one possibility: certainly this seemed to help whilst he was in the most extreme phase, and also had a general beneficial effect. However, it did not seem to have a direct effect on his belief during the months after hospital. Another possible source of change could be the care he received in the hostel. Informal counselling was offered in the hostel and occasionally issues such as bereavement were discussed. It is notable, however, that changes in conviction began immediately after the commencement of active SFT. It would be strange if the effects of, for example, medication, should begin just then. In short, it is difficult to rule out the above factors, and no doubt they made contributions. Yet, the fact that Jim changed specifically at the point of therapeutic intervention seems reasonable evidence that it made a direct and significant contribution.

Compared to standard SFT, this case involved a large number of sessions, approximately 19 in the first stage and many follow-ups. We doubt, however, that such prolonged work would be useful or necessary in all cases. Perhaps a more useful approach for such pervasive difficulties is an 'intermittent' model, with booster sessions at intervals of months if not years.

We do not assume, however, that this approach would be suitable for all types of delusion and person nor that it is more effective than other

approaches such as cognitive therapy (Jakes, Rhodes, & Turner, 1999). It seemed to fit Jim's situation for the following possible reasons: (1) he was terrified and seemed very motivated to stop the situation; (2) the perceived attacking entity was 'external'; (3) certain deliberate actions on his part did seem to have effects, for example, talking made him less anxious; (4) he was able, under at least with this approach, to form a working therapeutic alliance. Furthermore, SFT could be used flexibly to accommodate the above varying needs and also be responsive to his extreme emotional state (King, 1998).

An interesting feature of de Shazer's (1988) work was how he tended to focus discussion on the systemic features of the individual's life, for example, on the man's relationship with his wife. The work reported here began with a focus on the 'emergency' and how to cope, yet the long-term focus became a return to the community and a re-engagement in life-goals and ultimately a review of the meaning of his past and future. It might be argued that for a psychotic belief system and attendant emergency there exists a simultaneous 'parallel problem', for Jim, social isolation and fear of death, which engenders or feeds into the presented concerns. In a similar vein, White and Epston have spoken of systemic effects as a 'life-support' for the presenting concerns. How one can work, at what phase, and on what topic, may be interesting developments for SFT with psychosis.

A challenge this work presents is the position taken by the therapist towards the 'truth' of the delusion. For example, does one adopt a position of apparent agreement, silence, agreement to disagree and so on? We take the spirit of SFT to be a humanistic one of openness, acceptance, and respect. If one's words lead a client to believe one accepts a 'delusion', is that treating someone with respect, however, 'useful' it may be? In practice we have found this to be not a great problem for most clients since they seem to accept a position of 'neutrality' from the therapist who may use questions such as 'so, if X were to happen as you believe, what can you do?' That stated, in agreement with Flaskas (1997), we do believe that issues of 'the truth' or what 'really happened' to a person are sometimes, at some points in therapy, of central importance. Perhaps Jim needed many months and years of recovery until he could begin to re-connect the fragments of his overwhelming experiences. The ideal result, perhaps, would have been that Jim completely rejected his ideas of persecution thus making a relapse less likely. There is, however,

every reason for believing that insisting on such an aim would not have allowed the formation of rapport, or would have produced a very early dropout. Nelson (1997) has also argued that in using CBT with psychosis it may be more realistic to aim for 'partial modification' for some clients. Even the mildest suggestion that some Christians do not believe in 'Hell' was rejected by Jim. If the 'demons' return, however, we believe the techniques would be able, quite rapidly, to reduce his anxiety and preoccupations.

APPENDIX A

Dear Jim

This is just a short summary of some of our discussions. In the space of 2 years you underwent great and unbelievable pain. This brought you down: I doubt anyone could have undergone what you went through, and not suffer in some way. Time has passed, and now I see you beginning to rebuild your life.

During your down period, you saw what you thought was a terrible future and you were told that you would be judged in some horrible way. This has turned out not to be the case.

In our discussions you stated that only God can decide and that there might be many possible futures. Which one happens depends on what you do.

You have believed that demons would come to get you. This has not happened, time and time again. We have begun to wonder whether or not all this is an empty threat, a big con, something you were fooled into believing when at your lowest.

You say: God makes the decisions. Sometimes you feel afraid and almost seem to forget your own faith. But things are changing: during the last week, thoughts of demons only popped into your mind once and then you reminded yourself of your faith and the other thoughts went away.

Sometimes you get a pain in your stomach and chest: I wondered whether this was not anxiety, a sort of fear, something left over from all you have suffered.

When anxious, you told me the following can help:

- talk to someone
- get up and have a drink
- listen to the radio
- breath deeply

- say a prayer
- exercise
- keeping busy

When someone is down or afraid, it is easy to forget your strengths. But during the last few months I have seen you get stronger and stronger.

Jim, please read the letter a couple of times during the next few weeks and bring any thoughts to our sessions.

All the best,

John Rhodes
Clinical Psychologist

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