A Helping Hand: Solution-Focused Brief Therapy and Child and Adolescent Mental Health

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ABSTRACT

Solution-focused brief therapy is a relatively new approach for Child and Adolescent Mental Health Services in the UK. While the approach lacks the support of outcome studies compared with more conventional approaches, it is argued that the model does offer some specific advantages, and relates well to the range of problems which present and the manner in which many clients use the service. An outline of the approach is provided, along with an overview of research and comments on contraindications. A variety of clinical examples is used to illustrate how the approach works in practice. Concluding comments question the manner in which new approaches gain acceptance.

KEYWORDS

Child and Adolescent Mental Health Services, clinical practice, research, solution-focused brief therapy

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SOLUTION-FOCUSED brief therapy (SFBT) has been promoted in the UK for around 10 years, with clinicians from a variety of settings adapting the approach to their practice. As a social worker in an outpatient child and adolescent mental health service (CAMHS), I have been impressed by the contribution this approach can make to my service. After outlining the approach, its current research credentials, and contraindications, I illustrate a number of areas of potential relevance.

Origins of SFBT

The most specific crystallization of SFBT can be attributed to Steve deShazer and Insoo Kim Berg. Along with colleagues, in 1978, they established the Brief Therapy Centre in Milwaukee, USA, planning at the time to set up 'The MRI of the Mid-West' (Nunnally, deShazer, Lipchik, & Berg, 1986, p. 77), inspired by the brief family therapy model developed by Weakland, Fisch, Watzlawick, and Bodin (1974). From the outset they committed themselves to a trilogy of therapy, training and research. By 1984 their articles spoke of a shift away from Weakland et al.'s model, emphasizing a solution- rather than problem-focused approach, and a recognition that clients could often create their own strategies for change (deShazer & Molnar, 1984). Several techniques were found to operate like skeleton keys (deShazer, 1985), able to unlock a process of problem resolution without having to be tailored to the problem in question. Gradually, deShazer and colleagues articulated a set of assumptions and techniques named as SFBT. In practice these two aspects, assumptions and techniques, link to each other in a recursive manner. The techniques without the assumptions often fail to be of benefit, whereas the assumptions can be seen as propositions which can be tested out by using the techniques.

SFBT assumptions

- Presenting problems are seldom static – they usually vary in frequency and intensity.
- Clients often have resources to deal with their difficulties.
- Small steps can change a vicious cycle of problem maintenance to a virtuous cycle of problem resolution.
- The clinician's responsibility is not to offer the client solutions but to help them find their own.
- Problems fluctuate in their severity and exceptions are waiting to be found.

SFBT techniques

Problem-free talk

Once it is respectful and sensitive to do so, clients are invited to talk about aspects of their life other than their problems. They might be asked about how they cope, or about their work, or other aspects of their life in which they enjoy more success. As well as providing important information about family resources, this can also remind parents and children of abilities they may have forgotten, raising morale in the process.

In one family in which the teenage son was refusing to go to school the father had appeared ineffective in sessions. When asked about his work it emerged that he was a ticket collector with a fearsome reputation. Suddenly, he became a potential source of authority in the family, and a significant resource for securing the boy's return to school.

Goal clarification

Clients are invited to define their preferred outcomes in specific, concrete and measurable terms. In most cases, goals are used as the primary target for change. When parents are overwhelmed by concern goals are often stated vaguely and/or as an absence of the presenting problem, such as 'he'll stop being naughty'. A detailed description of the preferred behaviour also allows the clinician to ask if any of this has happened before. One parent, when asked what her 7-year-old son would be doing when he behaved better, identified occupying himself in play. When the family were asked if this had happened yet, the boy's sisters commented that it had, and gave examples.

Compliments

At the end of a session, and often throughout, clinicians comment on abilities and resources they have noticed both in parents and children. This again can alert clients to resources they may have lost sight of. A teenage boy who had unwillingly attended for help with soiling had told his mother that he was not going to say anything. He was complimented on his ability to stick to his plans, an important ability when dealing with soiling. He subsequently returned for individual sessions during which he devised effective strategies for gaining control of his soiling.

Pre-session change

Weiner-Davis, deShazer, and Gingerich (1987) found that two-thirds of people attending for first appointments were reporting either progress or times when the presenting problem was not happening. When parents are able to report this, the clinician has a useful opportunity to explore how this may have come about. Sometimes parents or children then identify strategies which, if continued, can resolve the presenting problem. In a family in which a teenage girl had been over-defiant it emerged that the mother had instituted a reward system the night before the appointment. In subsequent work the parent was able to build on this useful beginning.

Scaling questions

Scaling questions can be used to check for pre-session change, evaluate how much progress is needed and identify what would constitute one step forward. A mother attending with a teenage girl who had been running away from home, identified her anxiety as 10 on a scale of 0 to 10 at the time of referral, and 7 at the first appointment. It was judged that 3 would be good enough, and 6 would be achieved by the girl letting her mother know her whereabouts. For this family an improvement in communication was the main goal for change. When the family returned six weeks later the girl had continued to avoid running away, and the mother reckoned that they were at 3 on the scale due to improvements in communication.

Exceptions

Often parents can report times when the presenting problem does not happen, or happens in a different way. A mother who thought she always gave in when her daughter cried, spoke of taking her daughter to buy a new bed, the daughter crying when she didn't like her mother's choice, and of not giving in because she couldn't afford her daughter's preference. When the parents returned for the next appointment the mother proudly announced that she had consciously ignored her daughter's crying on one occasion, there turning out to be two on further discussion. Once confident that change was possible the couple continued to build on this ostensibly small step.

The miracle question

This particular question can help to clarify goals, identify existing progress, clarify options for action and act as a catalyst for change. Typically the question is worded as 'Imagine as you sleep tonight a miracle happens and the problems go away, but because you are asleep you don't know it's happened. When you wake in the morning, what would be a sign to you that the miracle has happened?' The mother of a strong-willed 4-year-old boy spoke of waking to find that he'd slept all night in his own bed. She then gave a rich description of how the rest of the day would be as a consequence. On their way home the boy told his mother that he was going to sleep in his own bed as he was 'a big boy now'. The boy was true to his word. The mother was so encouraged by this that she visited her parents the same day to insist that they stop undermining her authority. She also decided that two appointments were sufficient and after seven years has not been re-referred.

Research

When practitioners in a CAMHS turn to research on a particular therapeutic model they typically ask two questions. Is there evidence that the model makes a significant difference to presenting problems, and is there evidence that these improvements last?

Client satisfaction surveys were used from early on by deShazer and colleagues as an intrinsic part of SFBT, clients typically being contacted six, 12 and 18 months after treatment. The first study (deShazer, 1985) reported an 82% success rate in a six-month follow-up of 28 clients; success being defined by clients reporting that they had met their goals for therapy or felt that significant progress had been made. A later study (deShazer et al., 1986) reported a 72% success rate, at six months, with a 25% sample of 1600 cases. Studies by Kiser in 1988, and Kiser and Nunnally in 1990 (cited in deShazer, 1991) reported an 80.4% success rate which had risen to 86% when clients were re-contacted at 18 months. DeJong and Hopwood (1996) contacted 141 cases eight months after discharge. Goals were achieved by 45% and 32% had made some progress towards their goals. The studies were based on a mental health population, of which, in the DeJong and Hopwood study, 50% were aged under 19 years. George, Iveson, and Ratner (1990) reported a good outcome with 66% of a child and adult mental health population of 62 who were contacted six months after treatment. A caseload outcome analysis by Wheeler (1995a) offered tentative support for the usefulness of SFBT in a CAMHS.

In 1999 Gingerich and Eisengart presented a review of outcome research on SFBT to the International Family Therapy Association in the US. They listed 15 controlled studies, all carried out by investigators outside the original Milwaukee group (Cockburn, Thomas, & Cockburn, 1997; Eakes, Walsh, Markowski, Cain, & Swanson, 1997; Franklin, Corcoran, Nowicki, & Streeter, 1997; Geil, 1998; LaFountain & Garner, 1996; Lambert, Okiishi, Finch, & Johnson, 1998; Lindforss & Magnusson, 1997; Littrell, Malia, & Vanderwood, 1995; Polk, 1996; Seagram, 1997; Sundmann, 1997; Sundstrom, 1993; Triantafillou, 1997; Zimmerman, Jacobsen, MacIntyre, & Watson, 1996; Zimmerman, Prest, & Wetzel, 1997). The studies researched the following populations, respectively: depression in a university population; academic and personal concerns in a high school; unspecified problems in a high school; problem drinking in an employee assistance program; parent–child conflict in a university clinic; orthopaedic injury in occupational rehabilitation; schizophrenia in outpatient mental health; parent–child conflict in outpatient family counselling; drugs and discipline problems in a prison; adolescent offending in secure custody; child welfare in public social services; depression, hyperactivity and oppositional behaviour in a residential setting; marital difficulties in a

university clinic; behaviour problems in an elementary school; depression, substance abuse and anxiety in private practice. Of these, 13 reported improved client outcomes, and of 11 which compared the approach against standard treatments, seven reported that SFBT was as effective or more effective.

Zimmerman and colleagues (1996) explored the impact of a solution-focused approach with parents attending five parenting groups, using parents on a waiting list as a comparison. A standardized measurement tool was used to evaluate change, the researchers concluding that the study provided empirical support for the efficacy of a solution-focused approach to parenting.

Triantafillou (1997), studied the impact of staff using solution-focused techniques to deal with suicidality, anxiety and arousal disorders, motivational issues, anger management and crisis intervention in a residential setting for boys aged between 10 and 14 years. Contrasts were drawn between a treatment group of six boys and a control group of seven, using frequency of serious incidents and use of psychotropic medication as outcome measures. After a 16-week period, the number of serious incidents had reduced by 65.5% in the experimental group compared with 10% in the control group. In addition, two of the experimental group had stopped using medication, while use had increased in the control group by 60%. This was taken to be evidence of the approach having a positive impact on client outcomes, as measured.

Macdonald, as research coordinator for the European Brief Therapy Association, has also reviewed a variety of studies on SFBT (Macdonald, 2000). Burr (1993) followed up 55 children and young people seen at a children's clinic, six to twelve months after treatment. Of the 34 who were traced, 77% reported improvements. Macdonald, in a contribution to a forthcoming handbook on SFBT, also refers to process studies which have explored the impact of focusing on pre-session change and exceptions, and the use of the miracle question, compliments and scaling questions. (For example, Allgood, Parham, Salts, & Smith, 1995; Johnson, Nelson, & Allgood, 1998; Metcalf, Thomas, Duncan, Miller, & Hubble, 1996.) Macdonald takes the view that 'Solution Focused Brief Therapy process research is beginning to show us which elements of therapy are effective and for which clients. The outline which emerges is similar to that now being discerned in studies of other psychotherapies. The important difference for Solution Focused Brief Therapy is that many non-essential elements within therapy have already been discarded.' (Macdonald, personal communication, 2000).

To date then, whereas SFBT has been supported by client satisfaction surveys and process research, more work remains to be done to clarify whether controlled studies offer as much encouragement, especially with regard to the durability of the improvements which come about. Macdonald (1999), hoping to rectify this deficit, is currently co-ordinating a multi-site study into the effectiveness of SFBT.

Contraindications

Research studies, to date, demonstrate the wide variety of client populations with which SFBT is being used. In time, studies might identify particular problems for which the approach is most effective. For the time being contraindications tend to draw more on general issues. Talmon (1996), for example, advised that SFBT should not be used with clients who have specifically asked for something different, or in situations in which the clinician feels too scared to be able to trust the client.

In a CAMHS, parents do make specific requests on occasion, such as for diagnosis. Successful engagement often depends on meeting parents at the point at which they have arrived through their own thinking. When working with parents who suspected that there

was something odd about their son, the results of assessments were shared along with a list of the diagnostic criteria for Asperger's syndrome. They returned with a conclusion that he had sufficient features for them to use books written by parents of children with the condition, although they had decided that he did not completely fit the diagnosis. Through sharing the process of diagnosis it was possible to respect the expert knowledge they had of their son. The way was then clear to discuss how best to deal with his behaviour and liaise with his school.

Given that SFBT is essentially a conversational approach, there does need to be some scope for conversation to happen. It is unlikely, for example, that the approach could be used successfully with a client whose thinking is wildly irrational, or with a family who are too chaotic or conflictual. In some situations other steps have to be taken first before SFBT can be tried. A mother and father were referred because of their difficulty in working together. In the first interview there appeared to be no room for manoeuvre. For the second interview they were seen separately, and when asked about each other's qualities were better able to say something constructive. The second appointment ended with a sharing of these discoveries, much to each party's surprise and pleasure. This small area of mutual appreciation provided a basis for further joint work in which significant progress was made in reducing the arguing.

Relevance to CAMHS

In adapting SFBT to my practice in a CAMHS I find the approach to be relevant in a number of regards:

- reduction of problem saturation;
- appropriate to patterns of involvement;
- relevant to the variety of situations which present;
- a safeguard against cycles of blame;
- the enhancement of binocular vision.

Problem saturation

Parents are often preoccupied with concerns about their children when they present to a CAMHS. Many feel they that have run out of effective strategies. Many conclude that there is something 'wrong' with their child. Where the child clearly does have intrinsic difficulties, parents have often lost hope that they can make any difference to the child's future. White (1995) has referred to this type of thinking as 'problem saturation'. Problem thinking has become so pervasive that the parent forgets past successes and views the future with despondency. Frequently, the child thinks in a similar way. Picking up on the parent's negativity, their self-esteem and sense of self-efficacy are low, and they have little motivation to do anything different. As Street (1994) pointed out, negativity in a parent–child relationship frequently damages the attachment, and damaged attachment breeds negativity. SFBT can be particularly helpful in loosening the parent's despondency, enabling them to realize that their situation might not be as bad as they feared. For example, parents of a teenage girl with an eating disorder were reassured to realize that their daughter had already stopped using laxatives, as a step towards regaining her health. A clear statement of the parent's preferred future can also often be reassuring for children. A parent who had complained of her son's behaviour explained that she was aiming for a future in which she and her son had fun again. This was very different from the complaints he was more used to hearing.

Patterns of involvement

Talmon's book on single session therapy (1990) was sub-titled 'maximising the effect of the first, and often only, therapeutic encounter'. Talmon researched 30 mental health professionals, finding their modal number of sessions to be one, regardless of profession or therapeutic orientation. Talmon then contacted 200 patients seen by himself for only one appointment. Seventy-eight percent reported improvements, as did 79% of 60 clients contacted a year later.

After using SFBT for a while, I also analysed how often I was seeing people, and also found my modal number of sessions to be one: most clients being seen for six sessions or fewer. Interestingly, when I then analysed the distribution of involvements prior to my use of SFBT, there was little difference. This appeared to say more about how people used my service rather than the model I chose to use.

Beer (1992) reported on a pre-school child mental health service in which 70% of the cases were seen for three sessions or fewer. The audit of CAMHS in Scotland (Hoare, Norton, Chisholm, & Parry-Jones, 1996) reported that 61% of clients were seen for fewer than three appointments. Stallard and Sayers (1998) who offered the 'two plus one' model (Barkham & Shapiro, 1989) to 36 people who opted into a CAMHS found that three sessions were sufficient for most, and that 16 of these were seen only once.

Taken together, these findings suggest that many clients need less from a CAMHS than might be imagined. SFBT, by concentrating on what needs to change, what might bring about change, and what parents and children might contribute to this, matches well with the time commitment which many parents are likely to make to being involved with the service.

Table 1. Potential consequences of using solution-focused and problem-focused approaches in child mental health

Type of problem	*Solution-focused approach*	*Problem-focused approach*
Child normal. Parents/others misperceiving behaviour as abnormal.	Parents' perception shifts. 'Problem' evaporates.	Risk of reinforcing parents' misperception, and arguments over child's normality. Risk of premature discharge.
Child's symptomatic behaviour is unintentionally maintained by ineffective strategies.	Parents adopt more useful solutions. Problem disappears.	Risk of parents feeling criticized and arguments over solutions. Risk of premature discharge.
Child's symptomatic behaviour is a reaction to other issues in family.	Parents shift focus from child to other issues, with confidence that these can be tackled.	Risk of reinforcing parents' labelling of child, and arguments over aetiology. Risk of premature discharge.
Child has intrinsic difficulties.	Parents and child produce their optimum efforts in collaboration with other services.	Risk of explaining everything in terms of intrinsic difficulties. Risk of over-dependency on services.
Child responding to stresses outside of family.	Parents and child produce their optimum efforts in collaboration with other services.	Risk of explaining everything in terms of external stresses. Risk of over-dependency on services.

The variety of situations which present

Children referred to a CAMHS can be considered to fall into the following five groupings, as outlined in Table 1.

1. Child is normal but is misperceived by carers and/or teachers to be abnormal.
2. Child presents with abnormal behaviour as an unintentional result of parents and/or teachers using ineffective strategies.
3. Child is reacting to other issues in the family which are masked by the child's behaviour.
4. Child has intrinsic difficulties.
5. Child responding to stresses outside family.

Arguably, these situations range from being entirely resolvable with family resources to depending, to some extent, on resources external to the family. As outlined in Table 1, the consequences for the family can be significantly different, depending on whether the clinician's approach is mainly solution focused or problem focused.

One parent saw her daughter as having an eating disorder following the daughter's decision to lose weight. The girl had been overweight, her brothers and father still were, and the girl had become concerned about her health. When the mother was asked for signs of a good outcome, she clarified that she needed evidence that her daughter was taking care of her health and had enough self-control to prevent her weight plummeting. Armed with this information, the girl was able to demonstrate that she had learnt a lot about healthy lifestyles and was able to be sufficiently self-controlled to reassure her mother about her immediate future. Had we concentrated on the mother's fears about an eating disorder, we might either have demoralized the daughter or ended up arguing with the mother about her misperception.

In a family in which the parents were dealing with their daughter's tendency to cry excessively, they had for many years adopted a strategy of avoidance, to minimize their daughter's distress. In a second session the parents were asked what ideas they had about the daughter's behaviour. The father said he was wondering if the crying might be temper tantrums. On further discussion it was agreed that this fitted the facts well. When asked what ideas they had about dealing with temper tantrums they explained that they knew about setting limits and not giving into crying, although the mother thought this might be impossible for her. By the next appointment the mother had already surprised herself by not reacting when her daughter cried. Had we concentrated on deficits we may well have drawn attention to the parents' actions and appeared critical of parents who had been acting in good faith. They might have stopped attending, taking the view that they sought help for their daughter and were told it was their fault.

In a family in which an 8-year-old girl had become withdrawn and insecure, the mother's reply to the miracle question was that the family would be peaceful and relaxed in the morning. Further questioning revealed that this depended on the step-father controlling his temper more successfully and the mother being confident that he was committed to doing so. It emerged that the step-father suffered from a post-traumatic stress disorder relating to an experience in the armed services. An involvement with the adult mental health services was helping him to maintain self-control and subsequent appointments were attended by the couple to maintain their relationship. While a problem-focused assessment might have revealed the same information, the step-father may have felt that he was seen to be the cause of the girl's difficulties. A solution-focused approach ensured that the family maintained ownership of the assessment process, and were thus more committed to subsequent targeting of the intervention.

A mother was seen with a 3-year-old who was very defiant and had not started to talk. While speech and language assessment was organized, the mother was asked to say what

her ambitions for her son were and what she had been doing to realize these. It emerged that she had developed an impressive variety of strategies and looked forward to hearing him call her 'Mam'. Had a deficit-focused approach been used, her fragile morale could have been undermined, and an already complicated attachment might have been further weakened by feelings of futility. During subsequent appointments solution-focused questions continued to help direct attention to the boy's growing abilities and the strategies the mother was using to encourage them.

A family sought help with their second son who was becoming delinquent, the eldest son having already acquired a criminal record. The father had become despondent over the increase in delinquency on the housing estate where they had lived for many years, and listed many sources of distress including damage to their garden and the poisoning of their dog. After further discussion it was agreed that, while they couldn't control what happened outside their front door, they might be able to do something about what happened behind it. When the family were asked for examples of something different, the boy referred to a time when the mother hired a video which they watched and laughed at together as a family. Extra services were used to divert the boy away from delinquency while the parents did what they could to influence him at home. Had the conversations focused entirely on the difficulties, the parents' despondency may have prevailed and potentially undermined the impact of the diversionary activities.

Cycle of blame

Figure 1 outlines how a problem-focused assessment can perpetuate a negative cycle of interaction between clinician and family in a CAMHS outpatient involvement.

Parents often blame the child, while suspecting they may be at fault and open to blame by the clinician. Children often assume the fault is theirs, know of their parents' disappointment in them and expect to be reprimanded by the clinician. The clinician in turn is open to blame if the involvement is not effective. This risk has been further explored by Wolpert (2000), who analysed the extent to which blame and exoneration occurred with a sample of 10 families. She concluded that it may be useful for clinicians to 'hone their sensitivity to issues of blame and exoneration' and saw this as 'an important factor that may contribute to premature termination of treatment' (p. 128).

As Figure 1 shows, the moment the clinician chooses what to focus on when meeting a family may influence the subsequent involvement. It is at this point that SFBT can be particularly beneficial in establishing a more collaborative and constructive involvement.

A 10-year-old boy had been brought back to the department by his mother, aunt and grandfather, following a serious worsening of his challenging behaviour to his mother. He was asked what he had been doing to stop the deterioration, when he'd heard that he was coming back to the department. Without prompting, he identified all significant areas of concern along with steps he was taking and planning to take. As the family left, the aunt, who had previously viewed the boy very critically, said how reassured she was to know that the boy took their concerns seriously, and how much more hopeful she subsequently felt.

Binocular vision

When professionals become involved in other people's lives, it is important to maintain a balanced view of the people they are encountering. This can be thought of as a form of binocular vision – seeing not only the difficulties people come with, but also their strengths and resources, which may play a crucial part in the resolution of the difficulties.

Tollinton (1999), a retired clinical psychologist, was surprised by the behaviour of the professionals she encountered when her husband suffered a stroke. She and her husband

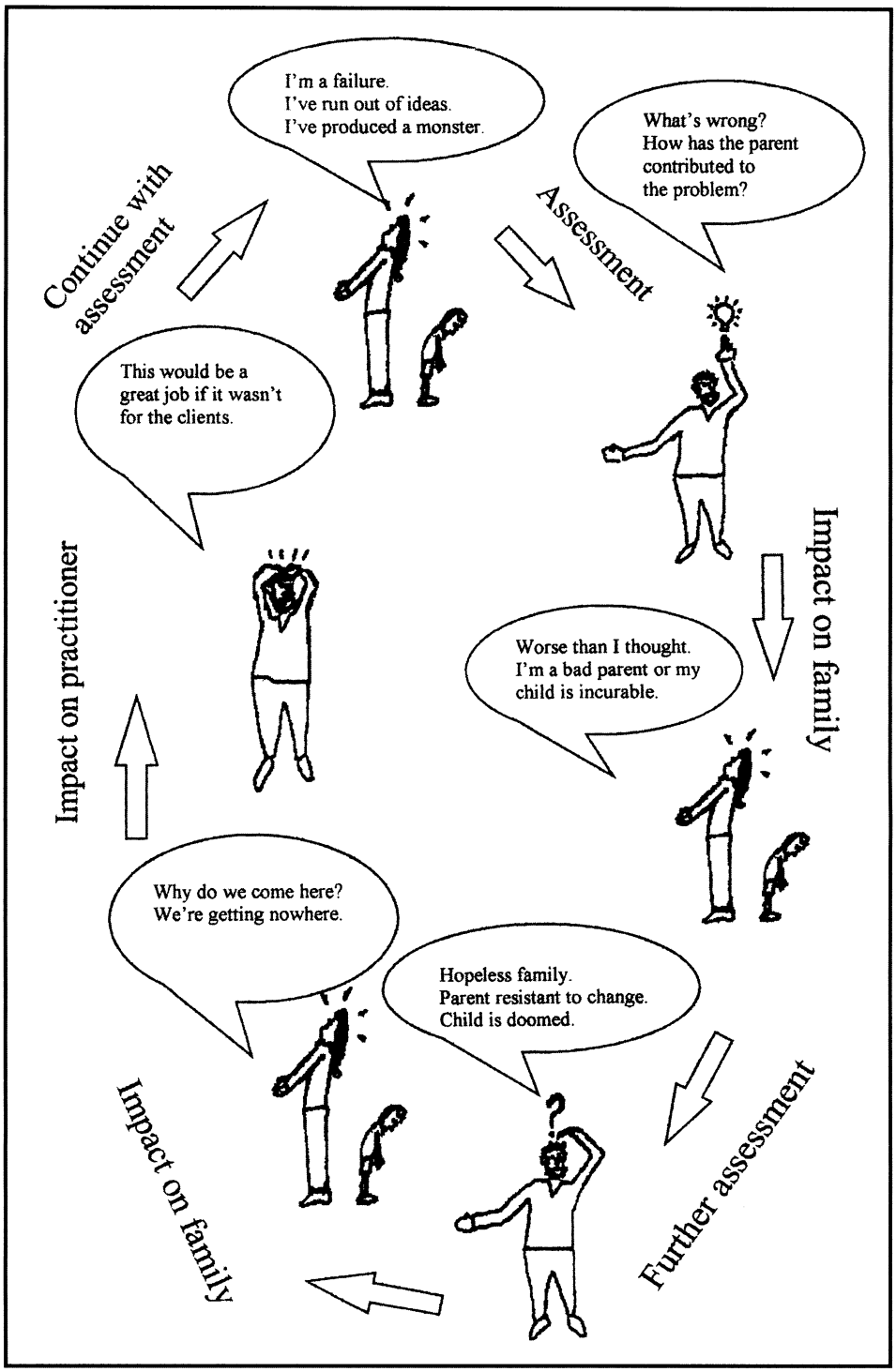

Figure 1. Cycle of blame.

found little 'natural kindness and psychological sensitivity' (p. 21). They noticed how feelings of 'disempowerment, loss of any sense of efficacy, (and) feelings of worthlessness' (p. 23) were engendered by professionals who adopted expert positions. Professionals who behaved differently played an important part in her husband's recovery. Tollinton found that 'Focusing on the solutions we sought and on small steps towards the goals we aimed towards was immensely helpful' (p. 22).

SFBT can easily be misunderstood as a device for seeing the world through rose-tinted glasses. In practice those who use this approach are more likely to use the techniques to established a balanced view, one that is less negative than might otherwise have come about.

An account has been given (Wheeler, 1995b) of a first interview with a mother with a fractious toddler. Commenting on the mother's strengths helped put her at ease. She then demonstrated more of her positive interactions with the child than might have happened had she felt criticized as a result of the conversation focusing on deficits. The child also settled, and was able to demonstrate more of his endearing qualities than might otherwise have been evident.

Conclusion

Since SFBT was first introduced into the UK there has been a growing interest in using the approach in CAMHS. SFBT has, understandably, generated a degree of scepticism and concern that the approach is not sufficiently adequate to the needs of those who present to the service. It is also probably too early to know whether the approach is useful because of its techniques, or because the techniques enhance the extent to which clinicians relate to clients in ways which existing studies show to be useful. Outcome research for SFBT based on random control studies is at a relatively early stage compared with that for some approaches which have been used for much longer in CAMHS. Studies drawing on client satisfaction speak more encouragingly of the usefulness of the approach and the durability of the changes which clients have reported. In the UK the drive towards a greater use of evidence-based practice is directing clinicians to treatments which are supported by 'gold standard' studies. However, the government is also urging clinicians to listen to the views of service users. Arguably, if clinicians can place confidence in the views of clients they will already be on fairly safe ground should they consider trying SFBT.

It is also worth considering that, from a historical point of view, therapeutic approaches have usually found a place in services before scientifically rigorous studies have confirmed their value. Therapeutic approaches have often been a matter of clinician preference. Miller (1994), an enthusiastic proponent of solution-focused brief therapy, reviewed the literature hoping to find that his preference for the approach was supported by outcome studies. While he found studies which suggested that SFBT was as useful as other therapeutic approaches, he found no evidence that it was a best choice. He was left with the conclusion that his preference was due mainly to personal enjoyment and client satisfaction. Perhaps these are stronger influences on clinician preference than we might otherwise suspect. Roth and Fonagy (1996, pp. 376–377) were of the view that 'On the whole, research has only limited impact on services', going on to comment that 'Clinicians are experts in their field, and on many issues may be ahead of empirically generated research findings . . .' Target and Fonagy (1996), having reviewed outcome studies relating to child and adolescent mental health, recommended that 'it is important that a variety of treatment approaches be maintained at an adequate level, so that clinicians have a choice in relation to a particular child's needs and family's circumstances.

It is certainly not enough to provide simply the treatment that has come out best in research studies of non-referred children with a single difficulty.' (p. 319).

To use a developmental metaphor, even established therapeutic approaches were young once. At one time SFBT may have been small enough to ignore. Over time, clinicians interested in the approach have adapted and developed SFBT to a stage of development which might now be looking like maturity. Suppose a miracle happened and a majority of clinicians considered SFBT to be a significantly useful contribution to a CAMHS. What would clinicians have noticed?

Further studies, in particular those coordinated by the European Brief Therapy Association, may, in time, provide one sign of this. Until then the responsibility will rest with us as clinicians to continue exploring how the approach may contribute to our work. For my own part, I already judge the model to be a useful asset as I endeavour to offer a helping hand to those who turn to me for help.

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