Solution-focused Group Methodology for Rehabilitation of People on Sick-leave

A minimized approach oriented towards the future or - Less is more -

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Preface

It has been a privilege to have had the opportunity to carry out these two development projects involving persons on sick-leave in Värmland County Sweden. A work where meeting group participants has always been enormously stimulating and hope-inspiring. When it comes to co-operation with the Social Security Office of Värmland, there seems to be an excellent organisation which, assisted by the local Karlstad office, has enabled us to carry out this project.

We would like to extend special thanks to the following people for their support of and participation in the projects:

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* Caroline Klingenstierna has, under supervision of Professor Lennart Melin, Uppsala University, composed "Effects of Solution-focused Brief GroupTherapy with clients on long term sick-leave", which is a controlled and randomised study describing our work concerning people on long-term sick-leave. The report is available from **www.solutionwork.com**

Karin Wallgrens controlled and randomised study of our following project, describes our work concerning people on sick-leave who may be expected to be on sick-leave for an extended period of time. The study will be available in English after publication from **wallgren.karin@telia.com**

Introduction

The background to the projects is our ambition to continue developing the solution-focused group methodology which we had laid the foundation of in a previous project called Job Workshop. This project focused on people with long-term occupational disabilities registered at the Employment Office. Our experiences from this work confirmed that the participants often felt healthier and more comfortable, so it came naturally to focus even more on people troubled by illness. Therefore, we started our collaboration with the Social Security Office of Värmland, which resulted in us carrying out two different projects during 2000-2001 using solution-focused group methodology for people on sick-leave. The projects have been linked to the controlled and randomised studies carried out by Caroline Klingenstierna and Karin Wallgren (see page 2).

The aim of the two projects was to create opportunities for development processes and increase the individual's recovery from illness.

Our first project was based on the very great increase in the number of people on long-term sick-leave in recent years. The target group for the project was people who had been on sick-leave between six months and three years.

Bearing our experiences from the first project in mind, we decided to try to apply similar methods at a much earlier stage of the sick-leave. Thus, the target group for the new project was people who had been on sick-leave for about 1-3 months, but who were considered to be in the danger zone of long-term illness.

Typical reasons for participants' being on sick-leave are stress-related troubles, pain problems (shoulders/nape of the neck/back) and psychiatric diagnoses such as social phobia, depression, panic disorder.

Method

Solution-focused group methodology

The group methodology that we have developed is based on the methods developed by e.g. Steve de Shazer, Insoo Kim Berg, BFTC, Milwaukee, and by Michael Hjerth, FKC (Centre for Solution-directed Brief Therapy), Stockholm. The result is a minimised model focusing primarily on individual development processes. This means that activities aim at participants activating themselves instead of creating activities for them. Thus, there are no shared activities such as physiotherapy, relaxation, or psychological tests. Instead, activities are characterised by group discussions aimed at bringing out participants' own resources and will to change their situation. The focus has been to construct solutions rather than investigating the causes of problems.

The short-term perspective aims at not only achieving change during the period of treatment but also, as far as possible, clarify and ensure permanence in the achieved goals and changes.

When dealing with a participant, we have assumed that the participant is the expert when it comes to his/her situation and that there is continuous change. Thus, our task has been to make this clear and, by means of solution-focused interviews and discussions, guide the participant in investigating and carrying out the changes he/she wishes to bring about.

As we have frequently illustrated and explained the questioning techniques and solution-focused instruments applied by us, activities have in certain degree taken on the nature of us training“co-therapists” rather than “treating” people. That is to say that participants have been given the opportunity to understand and learn in what way questions etc. may be helpful.

Inplementation

Participants project 1:	People on long-term sick-leave 6 months – 3 years
Treatment period:	Ten 4-hour days distributed over eight weeks.
Participants project:	2: People on sick-leave risking to remain so for an extended period of time
Treatment period:	Seven 3-hour days distributed over about five weeks.

We have based our way of working on the so-called PLUS model and the 4 S model worked out by Michael Hjerth.
For both groups we have had an introductory 3-day part, which in individual solution-focused discussions can be compared to a so-called “first discussion”.

P – Platform	Acknowledgement, coping, collaboration, exceptions, progress already made, what is the individual’s “project”?
L – Solutions (Lösningar)	Participant’s description of solutions and connections. The Miracle Question, clarifying follow-up questions.
U– Exceptions (Undantag)	What resources and progress are already at hand?
S – Scale/steps	Scales and working out the next step, summary and tasks.

At the remaining 4-7 meetings we have applied a follow-up model (4 S) which can be compared to the so-called “second, third, fourth discussion”.

S - Trace (Spåra upp)	What is better? Is there a positive, deliberate or random change?
S - Stabilise	Elaborate: visualise, clarify. Strengthen: show appreciation, praise and pay compliments.

S - Scale	Illustrate changes. Is this enough? Is this secure and sustainable?
S - Steps/Stay	What else is required (next step)? Or what is required for continued security/functioning?

Voluntary, individually adapted program

Group participation has been voluntary and participants have been able to discontinue treatment at any time without any consequences with regard to the Social Security Office. Participation has been possible regardless of the participant's degree of recovery and whether or not the participant has been able to formulate any thoughts or ideas concerning his/her future. For example, if a participant has not had the strength to participate during three hours, he/she has been able to participate in a way suitable to his/her situation, e.g. 1-2 hours per meeting.

What do we need to know?

During implementation we have attached particularly great importance to focusing questions and discussions on things which each participant has chosen to tell us. In this way try to show respect for the individual's right to tell us only things which he/she considers to be urgent or important to share with us. To begin with, we have no knowledge about diagnosis, sick-leave, family situation or vocational background. As we do not carry out any charting in the traditional sense of the word, we hope to be able to better listen to the participants and take his/her own story as a point of departure. Instead, we are initially interested in learning what the participant actually wants to achieve by joining the group.

Creating an attractive image of the future and the road there

By giving the participant an opportunity to visualise his/her situation and context when all problems have been sorted out, a description which can be compared to a "map" of the road ahead. The frames of reference are based on the participant's own experiences and skills and are usually in many ways linked to the current situation. In this way the participant's views on the goals' feasibility and attraction will emerge, which seems to contribute to optimal use of the participant's own resources in order to keep striving to step by step improve his/her situation.

Respect for the participant's right to formulate goals

We have been anxious to avoid, as far as possible, a situation where the participant feels that he/she is under pressure or is forced to bring about change. Instead, we try to let the participant provide the enthusiasm and have consistently respected the participant's right to formulate or refrain from formulating goals.

Illustrating change

During follow-up meetings we check and visualise the positive changes that have occurred since the previous meeting. We have consistently used the question – What

is better? It aims, among other things, at illustrating progress and show what has turned out to be the best way of handling the participant's situation. Other signs and conditions for further progress are identified by so-called scaling questions and, based on these, new steps (subsgoal) are identified. We continuously take into account how confident the participant is when it comes to sticking to or developing his/her goals in order to avoid, as far as possible, not realised success and failure.

Evaluation

Our continuous evaluation has consisted of gauging therapeutic alliance (Session Rating Scale), scaling questions plus oral and written remarks from the participants. As mentioned before, the projects have been evaluated by Klingenstierna/Wallgren (see page 2).

Group size

Most meetings have been in a large group, i.e. all participants, up to ten people. This group has often been broken up into smaller groups to discuss issues such as exceptions, coping, resources etc. When dealing with the Miracle Question we have used group sizes of 3-4 people.

A solution-focused approach seems to be helpful

Voluntary participation

Joining the group activities as well as leaving them has been up to each participant. It has been possible to participate on a trial basis or choose to participate during a smaller number of hours, etc. Our constant ambition has been to make participation as voluntary as possible in all respects. As no demands on participation are made, there are no arguments in favour of not trying. Some of the participants have confirmed that activities being voluntary have been helpful.

With a clear goal, the road there will emerge

We are convinced that a solution-focused working method is in many ways helpful when it comes to rehabilitating people on sick-leave. Just to illustrate one aspect, we would like to mention future prospects. A majority of the people we have met have been almost completely without goals or ideas or planning with regard to their future. Instead, focus has been on the past and the causes of their present situation. Starting from the solution-focused discussion, participants have begun formulating their thoughts regarding future goals without feeling this to be threatening or trying. The aim with the discussions has been to creating hope and carrying out in which way the participants will be able to use their own resources. It has been important that the goals have been broken down into small steps, so small that the participant can be sure to manage to take them.

The Miracle Question is very useful… but "What is better?"

In the efforts to visualise an image of the future, we have consistently used the so-called Miracle Question. The question has been enormously useful and we have found that the question, on several occasions, has had an enhancing effect when repeated in front of others in small groups. A number of the participants have confirmed that it has been helpful to hear the question or parts of the question repeated several times.

Thus, the Miracle Question has its indisputable merits when it comes to creating opportunities for starting a development process. However, we would like to emphasise the particular power in using the question – *What is better?* We have found that the question is of vital importance for tracing, stabilising and, by means of scaling questions, adapting positive changes to their context, regardless of them being due to deliberate decisions or random occurrences. Each follow-up meeting has started with this question - *What is better?* and the agenda of the meeting has been generated from the needs and wishes brought up when working on the agenda. As participants have been confronted with the question on a regular basis, it has been interesting to see that many of them have made a real effort during the week by keeping a "journal" of what has become better.

Basing our opinion on our experiences of working with the question – *What is better?* We strongly recommend use of this question, which seems to both strengthen and improve the development process.

It must take time…

… is an expression frequently used within medical care, rehabilitation, authorities and media. As we have interpreted it, several participants with stress-related/psychiatric diagnoses have claimed that this is a prerequisite for their recovery. Most common is probably that the expression is used to confirm that the person on sick-leave should not be rushed or feel that those around him/her "demand" a quick recovery, which of course would be with the best of intentions.

However, *it must take time* does usually not imply that one can clearly foresee what time perspective one is talking about or what efforts are required, nor does it imply that some diagnoses require a fixed number of months on sick-leave, etc. Instead, it is a way of saying that it *cannot* be clearly foreseen, but recovery lies a good way down the road. However, mentioning that *the time required is different* for different people offers the participant an opportunity or even a *choice* to be among those requiring, relatively speaking, shorter time.

It must take *time*! – Time for *what*? – Time for *recovery*! – What is the very *first* sign that you would notice telling you that you are beginning to recover? A solution-focused discussion aims at visualising various signs of progress. In this way, the future and the road there is filled with content, and discussions are increasingly being focused on *what* time is required for.

Our starting-point has been that activities can be offered participants having different kinds of diagnoses, different opportunities or being at different stages in their recovery. When evaluating the project, a majority of the participants stated that the group activities were offered to them *just at the right moment*, which indicates that the individual adaptation has been good.

Ill or well?

Black or white? In several discussions participants say that they can or cannot do something due to the fact that they are well or ill. Ill in comparison to what, or well enough for what? Using so-called scaling questions*, participants have been able to describe how changes occur in their recovery and in what way different "levels" in their recovery result in different situations. Consequently, we are not talking about participants being either ill or well. Instead, they can describe their recovery in relation to what they are well enough or too ill to do. In addition, scaling questions have been useful in several other contexts during the activities.
(* On the basic interview scale, 10 means completely well and 0 equals when things have been at their worst).

A few ideas for the future

We feel that the projects have worked very well in many respects. We have, however, some thoughts about possible development and adaptation of similar group activities.

Our program with three introduction days and a maximum number of follow-up group meetings may be completed with a few individual follow-up discussions, provided that the participant feels that he/she needs them. This would mean a prolonged treatment period but it will then include some of the more activity-focused changes (e.g. that the participant has rehabilitation conversations with his/her employer, starts work training or begins working part-time). The advantage is that the group activities allow more room for individual differences and are also adapted to the inertia in some of the care and rehabilitation sector.

Participants' periods on sick-leave usually vary between one and a few months in length. In several cases the sick-leave has been prolonged retroactively as late as two or three weeks after the end of the previous period. As far as we know, no participant has been declared fit against his/her will, but anxiety and pressure caused by not knowing have been great. Several participants have repeatedly mentioned that they in other connections, have not dared to tell that they have felt better, as they have feared to be considered healthier than they actually felt themselves to be and then be declared fit before they can envisage going back to work.

All in all it seems that anxiety concerning their sick-leave or delayed doctor's certificates has too much drained several participants' energy and possibly have had a checking effect on recovery. In a new project it would be interesting if its possible to increase confidence for the participants in questions about periods on sick-leave etc.

To conclude, we would like to say that it has been both interesting and stimulating but above all fun to be able to develop a treatment model purely aimed at the development process rather than introducing activities. We hope that You, the reader, can make some use of our experiences, and we shall welcome further development of our model.

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