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Posttraumatic Success: Solution-Focused Brief Therapy

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Results of several studies suggest that traumas need not be debilitating and that most people are resilient and even grow in the wake of a trauma. Understanding and highlighting the sources of this resilience and posttraumatic growth and focusing on hope and optimism help professionals foster these strengths in their clients, as opposed to focusing on what is wrong with them, which can have a discouraging effect. From a solution-focused perspective, the focus in treatment shifts from *posttraumatic stress* to *posttraumatic success*.

KEY WORDS: posttraumatic success, posttraumatic growth, resilience, solution-focused brief therapy, crisis intervention.

$$U_r = \frac{\sigma^2}{2E} = 0.5\sigma \in= 0.5\sigma\left(\frac{\sigma}{\mathrm{E}}\right)$$

Resiliency: What does not kill me, makes me strong.

Posttraumatic Stress

Experiencing trauma is an essential part of being human: history is written in blood. Throughout evolution, humans have been exposed to terrible events. Yet most people survive without developing psychiatric disorders. To be distressed is a normal reaction to the horror, helplessness, and fear that are the critical elements of a traumatic experience. The typical pattern for even the most catastrophic experiences, however, is resolution of symptoms and not the development of *posttraumatic stress disorder*. Only a minority of the victims will go on to develop posttraumatic stress disorder, and with the passage of time, the symptoms will resolve in approximately two-thirds of these (McFarlane & Yehuda, 1996).

Seligman (2002) observed that exposure to uncontrollable negative events leads to *helplessness*. In a series of famous experiments in the 1970s, Seligman demonstrated that animals subjected to pain by being given electric shocks which they had no control over, became passive, developed symptoms that resemble depression, and were more prone to physical ailments. This passivity or helplessness persisted even if later they did have the power to control the situation and escape the shock.

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Additional studies have demonstrated that this phenomenon of *learned helplessness* also applies to humans. To explain these findings, Seligman proposes that individuals develop expectancies about the occurrence of adversity in their lives. These expectancies are powerful predictors of behavior. The expectancy that adversity will continue and that one will be powerless in its wake leads to helplessness, passivity, withdrawal, anxiety, depression, and even physical illness. In contrast, expectations of control engender persistence, the ability to cope, and resilience to depression and physical health problems.

Seligman's experiments focused upon the group of dogs that became anxious, passive, and depressive, with some even dying, when their cage was subjected to an electric charge. Only later, attention was given to the dogs that, although unable to escape, had continued looking for a way out. What had caused these dogs to persevere and survive?

Children who grow up in troubled circumstances have a statistically higher chance of developing problems at a later stage than children with a "normal" childhood. However, correlation is not the same as cause. Look at these two generally accepted statements:

- Child has difficult youth, thus will suffer problems in the future.
- Adult has problems, thus had difficult childhood.

Neither statement is correct. The idea that what a child experiences during his youth determines his future, is too simplistic. One would then assume that the child is a passive vessel and that childhood experiences will unavoidably overshadow the rest of his life. Rather, it is the manner in which the child deals with these early experiences that determines to a great extent what the outcome will be.

Furman (1998): "It's natural to think that our past has an effect on how our future will turn out, but we rarely look at it the other way around. The future—that is what we think it will bring—determines what our past looks like" (p. 81). If you are depressed, the past appears darker, if you are in love it appears somewhat brighter. Therefore, it might be helpful to ask your therapist the following question prior to a therapy: "How shall I view my past once we are finished here?" Compare this with a movie that you have seen and enjoyed but that your friends later criticize: this is likely to influence your perception of the film.

O'Hanlon (1999) proposes a nice way of working in the present toward the future to resolve trauma. First of all, this involves the acknowledgment of the facts along with the present and former inner experience of the trauma. Next, it focuses on helping clients' value, own and associate with dissociated aspects of themselves. Finally, it helps clients develop a clear sense of a future with possibilities.

Pathways to Possibility

Duncan, Hubble, and Miller (1997) state that their treatment failures taught them three lessons which, although conceptually simple, are difficult to implement: all theoretical models have limited applicability; the therapeutic relationship is more valuable than expert interventions; and what clients know, think, feel, and want has far more relevance to problem resolution than the favored academic conceptualizations. Pathways to impossibility occur when there is anticipation of impossibility either by the therapist or the client or by both due to therapeutic traditions or conventions; when therapist and client persist in a therapeutic approach that is not working; or when the client's motivation is ignored. There is no such thing as an unmotivated client. Clients may not share the goal of the therapist, but they certainly hold strong motivations of their own. When

psychotherapy is changed from theory directed to client directed, then possibilities emerge. This involves learning the client's theory of change and adapting the therapy to that theory as a pathway out of impossibility.

Duncan, Miller, and Sparks (2004) believe that feedback from clients is essential and improves success. Therapists do not need to know in advance what approach to use for a given diagnosis but rather whether the current relationship is a good fit and is providing benefit, and, if not, they need to be able to adjust and accommodate early enough to maximize the chances of success.

O'Hanlon and Rowan (2003) add to this the importance of transforming the belief patterns of both therapist and client to encompass the possibility of change, thus drawing attention away from beliefs in the impossibility of change and from ideas that blame, disempower, or invalidate clients or that see clients as nonaccountable.

Story

During the French Revolution, a lawyer, a doctor, and an engineer were sentenced to death. The lawyer was the first to approach the guillotine. "Blindfold?," asked the executioner. The lawyer did not want to be seen as a coward and replied: "No blindfold." "Do you want to lie face up or face down?," asked the executioner. "Face up," said the lawyer. The executioner then, using an axe, cut the rope supporting the razor-sharp blade. The guillotine fell but jammed just above the lawyer's neck.

"Sorry," said the executioner. "I checked everything this morning, as I always do." The lawyer immediately seized the opportunity. "If you read through the executioner's handbook, you will see that it says that if the guillotine does not work, the condemned person goes free." The executioner read through the handbook, saw that the lawyer was right, and let him go.

The doctor was next in line. "Blindfold?," asked the executioner. "No blindfold," said the doctor proudly. "Face up or face down?," asked the executioner. "Face up," said the doctor. Again the executioner swung the axe and cut the rope. Again the guillotine jammed, stopping just above the doctor. "This is unbelievable," said the executioner. "Twice in a row, this I have never seen before. This morning I really checked everything well, but rules are rules and I have to obey them. You are also free."

The engineer came next. In the meantime, the executioner had double-checked the guillotine thoroughly and everything seemed to be working. "Blindfold?," asked the executioner. "No blindfold," replied the engineer. "Face up or face down?," asked the executioner. "Face up," said the engineer. As the executioner was about to cut the rope for the third time, the engineer exclaimed: "Wait! I believe I see what the problem is!"

Resilience

Professionals pay much attention to diagnosis and the negative consequences of posttraumatic stress and posttraumatic stress disorder. Now the subject is also being approached from a different angle: what do people do to survive and what makes them strong? In this, the terms resilience and posttraumatic growth come to the fore. Resilience (Latin: resilio = I bounce back) is defined as the ability to survive, recover, and persevere in the face of various obstacles and threats. If a person was asked "Did your difficult childhood make you stronger or weaker?," the reply is likely to be that it actually made him stronger: "What does not kill me, makes me stronger." Bonanno, Rennicke, and Dekel (2005) state that resilience is often the most commonly observed outcome following a traumatic event.

A good way of exploring a client's resilience is to look for fluctuations within the experience of the problem: ask clients in detail about the times they did not (or to a lesser extent) experience the problem when they expected they would, find out what happens as the problem ends or starts to fade, and ask why the problem is not worse.

It is also helpful to look for success stories in the past. How was the client able to survive or find protection? Achieving a sense of distance from one's negative past actions and a sense of connection to one's positive past actions promotes a favorable view of the present self (Ross & Wilson, 2002).

Drugan (2000) carried out research into the neurochemistry of stress-resilient and stress-vulnerable animal subjects. During experiments, the release of neurosteroids differed in both groups. In the stress-resilient group, positive neurosteroids are released, leading to reduced stress and anxiety and behavioral and neurochemical stability. The level of gamma aminobutyric acid is enhanced. Specific neurochemical receptors or drug recognition sites in the brain are found to specifically bind minor tranquilizers, such as valium. These benzodiazepine receptors are associated with the major inhibitory neurotransmitter gamma aminobutyric acid. There is also impaired emotional memory of stressful events and less rumination.

In the stress-vulnerable group, negative neurosteroids are released, leading to high stress and anxiety and both behavioral and neurochemical instability. The level of gamma aminobutyric acid in the brain is reduced. There is enhanced memory of stressful events and increased rumination. Drugan's conclusion is that active behavioral coping or stress control is associated with the enhanced release of a valium-like substance in the brain.

Studies of early trauma and neglect reveal that neural structure and function within the brain can be severely affected and lead to long-lasting and extensive effects on the brain's capacity to adapt to stress. If a certain pattern has been stimulated in the past, the probability of activating a similar profile in the future is enhanced. If the pattern is fired repeatedly, the probability of future activation is further increased. The increased probability is created by changes in the synaptic connections within the network of neurons. This is called Hebb's axiom: "neurons that fire together, wire together."

However, the creation of new neural integrative links may be a learning process that remains possible into adulthood. Our brains retain the ability to continually reshape emergent properties that allow us to learn and grow with new experiences (Siegel, 1999). By focusing on resiliency, coping, and competencies (solution talk), new—positive—neural networks will emerge and old—negative—ones will "die away."

A recent study (Byrd-Craven, Geary, Rose, & Ponzi, 2008) shows that extensive discussions of problems and encouragement of "problem talk," rehashing the details of problems, speculating about problems, and dwelling on negative affect in particular, lead to a significant increase in the stress hormone cortisol, which predicts increased depression and anxiety over time.

Rubin (1996) states that people who as a child have endured traumatic experiences actually changed little—when looking at their inner qualities that enabled them to overcome these experiences and also at the strategies and adaptations that they used to that effect. Still present is the ability to cope with pain in a way that prevents it from becoming overwhelming, as is their ability to withdraw when the outside pressure becomes too high. The proficiency in finding other sources of support is still present in their later lives, along with the ability to feel involved in something beyond them, which is reflected in the need to feel useful, for

example, by helping others who are having similar experiences. The determination, with which they as a child overcame obstacles, persists as they work toward their goals as adults. And this is particularly visible in their refusal to perceive themselves as victims, despite the hardships of their lives. They reject the culture of victimization because they see that as a trap for those who believe in it. These events may have determined their past but they refuse to let them dominate the present: "This is what has *happened* to me, not what I *am*."

Exercise 1

This exercise is suited for yourself or for your client, who comes for help in psychotherapy.

Do you see yourself (or does your client see himself) as a *victim* or as a *survivor*? If you see yourself as a victim, it becomes more difficult to play an active role in shaping your life. You were unable to do anything about what has happened to you and you expect that you cannot change much about the way the rest of your life pans out. You probably feel powerless and feel that you have lost control. However, when you see yourself as a survivor, the possibility of a more active role becomes apparent. It offers the opportunity to organize and take control of your life, despite what you have experienced. This initiates a spiral of positivity and more control. The following four-step exercise can help you to find out which role you want to play in the rest of your life, that of victim or survivor.

1. How would you like to see your life in a month's time? The same people and circumstances are still present, but you feel a little less influenced by what you have experienced.
2. If you think about your answer to the previous question, that is, your goal in a month's time, how would you then think and feel, and how would you behave in order to reach your goal if you see yourself as a victim?
3. Answer the same question, but now from the perspective of a survivor.
4. What differences do you notice? What will you be doing differently? Which attitude is the most helpful to you?

Dolan (1998) states that overcoming the immediate effects of abuse, loss, or other trauma and viewing yourself as a survivor rather than as a victim are helpful steps but are ultimately not sufficient to help people fully regain the ability to live a life that is as compelling, joyous, and fulfilling as it used to be. People who remain at the survivor stage see life through the window of their survivorhood rather than enjoying the more immediate and unobstructed vision of the world around them that they previously held. All experiences are evaluated in terms of how they resemble, differ from, mitigate, or compound the effects of past events. This diminishes their ability to fully experience and enjoy life and is responsible for the flatness and depression reported by so many people who categorize themselves as survivors.

Hope and Optimism

As a political dissident, Solzhenitsyn (1973) was for many years banished to a Russian labor camp. In discussing corruption of prisoners in the camps, he says he is not going to explain the cases of corruption: Why would we worry about explaining why a house in subzero weather loses its warmth? What needs to be explained is why there are houses that retain their warmth even in subzero weather.

Hope is like a journey: a *destination*, a *map*, and a *means of transport* are needed. Research on the subject of hope has shown that it is important to have a goal and ways to reach that goal. Hopeful people have a clearer goal (destination) than nonhopeful people. They also have

a clearer image of the route via which they can reach their goal: they have a *mental map*. In addition, they believe that they themselves can do something to get closer to their goal (they are their own means of transport). And should the route to the goal be blocked, optimists will think of an alternative more easily and will continue to feel better than pessimists. These three factors are so closely connected that if you have a grasp of one, chances are high that the rest will follow. There is a connection between optimism and hope.

Exercise 2

If you want to (re)gain a glimmer of hope, even in crisis situations, ask yourself (or your client) the following questions:

- What helped in the past, even if only marginally?
- How do I cope with everything that is going on and all I have gone through?
- How do I succeed in getting from one moment to the next?
- Could it be worse than it is? Why is it not worse?
- What does my social environment say I do well, also in very bad times?
- Imagine that in 10 or 15 years, when things are going better, I look back on today, what will have helped me to improve things?
- Suppose there is a solution, what difference would that make, what would be different—and, more specifically, better?

Story

A severely ill man was in hospital. The doctors had given up any hope of a recovery. They were unable to ascertain what the man was suffering from. Fortunately, a doctor famous for his diagnostic skills would visit the hospital. The doctors said that maybe they could cure him if this famous doctor was able to diagnose him. When the doctor arrived the man was almost dead. The doctor looked at him briefly, mumbled *moribundus* (Latin for *dying*), and walked over to the next patient. A few years later the man—who did not know a word of Latin—succeeded in finding the famous doctor. "I would like to thank you for your diagnosis. The doctors had said that if you were able to diagnose me, I would get better."

Seligman (2002), founder of the *positive psychology* approach, shifted his attention from *learned helplessness* to *learned optimism*. He undertook research into the factors that lead people to perceive an event as positive or negative and their reasoning behind this. Pessimistic people attribute negative events particularly to *stable*, *global*, and *internal factors*. They say: "Things never go right with me" (stable), "I will never be happy again" (global), and "I am good for nothing" (internal). They attribute positive events to *temporary*, *specific*, and *external factors*. They say: "That was only luck, which had nothing to do with me," if something positive happens.

Optimistic people think in the opposite way. They attribute positive events to stable, global, and internal factors. If something positive happens, that does say something about them, for example, "I really am valuable." Optimists attribute negative events particularly to temporary, specific, and external factors. They might say: "I could not do anything about it, because he threatened me." Thinking in a pessimistic way, especially about negative events, leads to expectations of hopelessness.

Einstein said: "I would rather be an optimist and a fool than a pessimist who is right." People who think pessimistically run more risk of becoming depressed than people thinking optimistically. However, a little pessimism at times cannot hurt. It forces people to confront reality, and depressed people tend to have a more realistic view of the world. Every day could be your last; you could be involved in

a traffic accident or catch a fatal disease. Depressed people harbor few illusions about how safe and predictable the world and life actually is. Yet it turns out that we feel better and happier if we do hold these illusions and are able to preserve them.

Optimism and pessimism are relatively stable personality traits, but they can be influenced by the way someone acts and by what he is focusing on. Optimism contributes to more adaptive survival strategies, namely more positive reappraisal, better coping abilities, and more use of positive distractions (hobbies and exercise).

Research has revealed that even people with a pessimistic nature felt happier if over the course of a week they made notes of when in the past they had been at their best; every day, during a week, they would note down something about their strengths; express gratitude to someone whom they had not yet properly thanked; or made a note of three good things that were happening in their lives. Six months later, these people were still feeling happier, although the exercise took place over a period of only 1 week. Research has also shown that happy people are optimistic about their future and that optimistic people are in better health than pessimistic people. Four positive elements significantly contribute to a happy life (Bannink, 2007a). Happy people like themselves, are mostly extrovert, have the idea that they are in control and are optimistic. The question relevant to all four is does optimism make people happier (A) or are happy people more optimistic (B)? It turns out that A leads to B and B leads to A.

The results of several studies suggest that traumas need not be debilitating and that most people are resilient and even grow in the wake of a trauma. Understanding the sources of this resilience and posttraumatic growth will help psychologists foster these strengths in their clients, as opposed to focusing on what is wrong with them, which can have a discouraging effect. Tedeschi and Calhoun (2006) developed the Posttraumatic Growth Inventory, an instrument for assessing positive outcomes reported by persons who have experienced traumatic events. It includes factors of New Possibilities, Relating to Others, Personal Strength, Spiritual Change, and Appreciation of Life. Women report more benefits than do men, and persons who have experienced traumatic events report more positive change than do persons who have not experienced extraordinary events. The Posttraumatic Growth Inventory is modestly related to optimism and extroversion.

Solution-Focused Brief Therapy

Solution-focused brief therapy (SFBT) differs from traditional forms of psychotherapy (Bannink, 2006a, 2006b, 2007a, 2007b, 2008a, 2008b; de Jong & Berg, 2002; de Shazer, 1985). Also the approaches to trauma are different, as Table 1 illustrates. The focus in SFBT is on the preferred future and the steps clients can take to reach this future. A meta-analysis (Stams, Dekovic, Buist, & de Vries, 2006) shows that although SFBT does not have a larger effect than traditional forms of psychotherapy, it does have a positive effect in less time and satisfies the client's need for autonomy. SFBT revolves around four main questions. These questions can help clients to (re)gain hope, even in crisis situations:

- What is your best hope?
- What difference would that make?
- What is already working in the right direction?
- What would be the next step (or next sign of progress)?

Dolan (1991): "With solution-focused questions the therapist asks the client to describe the smallest signs of progress one by one and

TABLE 1. Differences in Therapeutic Approaches to Trauma

Traditional approach to trauma	Solution-focused approach to trauma
Therapist is the expert, gives advice to client	Client is the expert, therapist asks questions
Therapist's theory of change	Client's theory of change
Conversations about what the client does not want (the problem)	Conversations about what the client does want instead of the problem
Client is viewed as damaged (deficit model): how is the client affected by the traumatic experiences?	Client is viewed as influenced but not determined, having strengths and abilities (resource model): how did the client respond to the traumatic experiences?
Clients are (sometimes) seen as unmotivated	Clients are always motivated (although their goal may differ from that of the therapist)
Remembering and expressing affect are goals of treatment	Goals are individualized for each client and do not necessarily involve remembering and expressing affect
Interpretation	Acknowledgement, validation, and conversations about possibilities
Past and problem focused	Future and solution focused
Problem is always there	Exceptions to the problem are always there
Long-term treatment	Variable/individualized length of treatment
Coping mechanisms need to be learned	Coping mechanisms are already present
Conversations focusing on insight and working through the problem	Conversations focusing on accountability and action; insight may come during or after treatment
Sometimes feedback from client at end of therapy	Feedback from client after every session
Therapist defines end of treatment	Client defines end of treatment
Success is defined as the lessening or ending of the problem	Success is defined as the expansion of what the client wants instead of the problem and reaching the preferred future

encourages her to then carry out the smallest and easiest of these. This enables the client to experience in a safe and gradual manner control over the symptoms, without becoming afraid or feeling overwhelmed by tasks that she is not yet ready for. These small changes may pave the way for increasingly large changes, but then in such a way as to prevent relapse" (p. 47).

Solution-focused questions are very effective in encouraging clients to participate in and develop their own treatment plan, while implicitly a context of hope is also being created. Clients relate that this way of looking at their recovery process has influenced many aspects of their lives positively because they learned to see that what they do is good, healthy, and effective.

Posttraumatic Success

As an example of posttraumatic success, Frankl (1963) is often cited. He says of his stay in a German concentration camp that a prisoner who no longer believed in the future—his future—was doomed. He describes an incident where he staggered along in a row of prisoners on his way to the work area, in the cold and without food. He forced himself to think about something else. Suddenly, he saw himself standing on the stage of an auditorium where he was giving a lecture about the psychology of the camp system. In this way, he succeeded in lifting himself above the suffering of the moment and was able to view the torment as if it already were in the past. His focus on the future saved him for that

moment. And this vision of the future even became reality as after the war he conducted many successful lecture tours. In his *logotherapy*, Frankl explains that the meaning in suffering is resilience itself: the trick is to handle as well as possible the challenges that we face in life.

Furman (1998), a solution-focused psychiatrist, asked the readers of two Finnish magazines who had endured difficult childhoods to reply to three questions relating to their experiences:

- What do you think helped you survive your difficult childhood?
- What have you learned from your difficult childhood?
- In what way have you managed in later life to have the kind of experiences that you were deprived of as a child?

The nature of the 300 or so replies convinced him of the ability of human beings to survive almost any trauma. This gave him the belief that people can view their past—including even the most extreme suffering—as a source of strength rather than of weakness. "Our past is a story we can tell ourselves in many different ways. By paying attention to methods that have helped us survive, we can start respecting ourselves and reminisce about our difficult past with feelings of pride rather than regret" (p. 56).

O'Hanlon (1999), a solution-focused psychotherapist, who introduced the term *posttraumatic success*, gives some guidelines for therapy with survivors:

- Find out what the client is seeking to gain from treatment and how he will know when the treatment has been successful.
- Ascertain to the best of your ability that the client is safe. If not, take whatever steps necessary to ensure this.
- Do not assume that the client needs to go back and work through traumatic memories. Some people will and some would not. Remember that everyone is unique.
- Look for resources and strengths. Focus on underlining how the client made it through the abuse and what he has done to cope, survive, and thrive since then. Look for nurturing and healthy relationships and role models he had in the past or has in the present. Look for current skills in other areas. Have the person tell you how he stopped himself from acting on destructive impulses, got himself to seek therapy, and so forth, despite enduring the aftereffects of trauma.
- Validate and support each part of the person's experience and self.
- Make provisions (e.g., contracts) for safety from suicide, homicide, and other potentially dangerous situations if necessary. Make these mutual.
- Stay focused on the goal of treatment rather than getting lost in the gory details.
- Do not give the impression that the person is "damaged goods" or that his future is determined by trauma. Remember that change can occur in the interpretations and actions or interactions associated with the events.
- Gently challenge self-blaming or invalidating identity stories the person has or has accepted from others.

O'Hanlon also describes *the three C's of spirituality* as sources of resilience. *Connection* means moving beyond your little, isolated ego, or personality into connection with something bigger, within, or outside yourself. *Compassion* means softening your attitude toward yourself or others by "feeling with" rather than being against yourself, others, or the world. And *contribution* means being of unselfish service to others or the world.

Exercise 3

Imagine you have become an old and wise person and you look back on this period of your

life. What do you think this old and wise person would advice you to do in order to get through the present phase of your life? What would this person say that you should be thinking of? What would this person say that would help you the best to recover from the past? What would this person say how you could console yourself? (And how, from this person's view, could psychotherapy (if needed) be most useful to you?).

Tedeschi and Calhoun (2004) offer some important caveats on posttraumatic growth:

- Posttraumatic growth occurs in the context of suffering and significant psychological struggle, and a focus on this growth should not come at the expense of empathy for the pain and suffering of trauma survivors
- For most trauma survivors, posttraumatic growth and distress will coexist, and the growth emerges from the struggle with coping, not from the trauma itself
- Trauma is not necessary for growth, individuals can mature and develop in meaningful ways without experiencing tragedy or trauma
- Trauma is not 'good' in any way, life crises, loss and trauma are seen as undesirable
- Posttraumatic growth is neither universal nor inevitable. Although a majority of individuals experiencing a wide array of highly challenging life circumstances experience posttraumatic growth, there are also a significant number of people who experience little or no growth in their struggle with trauma, and this sort of outcome is quite acceptable.

Conclusion

Bannink (2007b): 'Brief interventions are en vogue. Both psychotherapy and waiting lists should and can be shorter. No longer the 'moaning and complaining' attitudes of clients should be reinforced, clients should be strengthened and stimulated to undertake positive action. The focus in psychotherapy should shift from impossibilities to possibilities and from posttraumatic stress to posttraumatic success. Other implications of SFBT are that training in diagnostic and treatment methods of psychopathology can become shorter and be replaced by training in SFBT. In this scenario a lot could change for the better in mental health care, for both clients and therapists' (p 93).

Acknowledgments

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