Solution-Oriented Therapy and Rogerian Nursing Science: An Integrated Approach

Linda K. Tuyn

This article describes an approach to counseling and therapy that integrates concepts from Martha Rogers' science of unitary human beings with a contemporary, strategic school of therapy called brief, solution-oriented therapy. The purpose of this discussion is to stimulate clinicians' interest in solving human problems by creative use of client strengths and patterns of living. A theoretical discussion of Rogers and of solution-oriented therapy is followed by many examples of clinical application from the author's practice. Resources for further learning are recommended.

MOST CLINICIANS who are fascinated by Martha Rogers' ideas about the nature of reality and the science of nursing will also admit feeling challenged and even stymied at times in applying these ideas to practice. However, Rogers' views regarding human rhythms, pattern, and the relative present (Malinski, 1986; Rogers, 1986; Sarter, 1988) can be shown to have great meaning for mental health nursing practice in a variety of clinical applications. In addition, there is a "new wave" in psychotherapy called brief, solution-oriented therapy (de Shazer, 1985; O'Hanlon & Weiner-Davis, 1989) that offers clinical techniques that integrate beautifully with Rogerian nursing science, outlining methods that can assist the nurse in forming operational descriptions of Rogers' abstract concepts. This article will bring together theoretical concepts from the science of unitary human beings and brief, solution-oriented therapy, and then demonstrate how this integrated approach promotes effective counseling and therapy in mental health nursing practice.

THEORETICAL DISCUSSION

Essential Rogerian Concepts

For use in counseling, there are two major Rogerian concepts essential to this approach. The first is the rhythmic, patterned nature of human experience, and the second involves attunement to what Rogers terms the relative present (Malinski, 1986). Addressing the first involves accepting the assumption that rhythmic phenomena is integral to all of life, from the smallest subatomic scale to the movement of the heavens. In human terms, we perceive and experience rhythms and patterns in, for example, our sleeping and waking cycles, menstrual cycles, the rhythmic functioning of our circulatory, nervous, and respiratory systems, exercise and rest patterns, and eating patterns. One could say we continually create and define who we are in our patterns of living.

Patterns in our day-to-day living often go unrecognized; for instance, the busy person who eats a nourishing breakfast then becomes so involved in a work project or child care that he or she forgets to eat for 5 or 6 hours, then quickly consumes whatever fast food is available may be totally unaware of this as a repeating pattern. A simple change in the patterned behavior of going too long without food may enhance the person's energy level, nutritional status, and weight control.

From Decker School of Nursing, State University of New York at Binghamton.

Address reprint requests to Linda K. Tuyn, M.A., R.N., C.S., Decker School of Nursing, State University of New York at Binghamton, Binghamton, NY 13902-6000.

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Similarly, relationships among people may be observed with an eye (and ear) for rhythms. Distancing and pursuing, made popular by the Bowenian school of family therapy (Bowen, 1978; Guerin, 1976) is a commonly perceived interactional rhythm between two people in an intimate relationship (i.e., husband and wife, parent and child). In most family groups, members take action to meet their needs for separateness and autonomy balanced with actions to achieve closeness and belonging, and often a rhythmic pattern can be observed. Who has not ended a marathon week-long get-together with extended family saying, "That was satisfying, and it will do for a while."? And the ebb and flow, ups and downs of even the best of marriages are something we are wise to expect; no relationship exists on an unchanging level of intimacy, pleasure, and delight in the other.

Regarding symptomatic behavior as rhythmic in nature is of particular importance in counseling and therapy. For example, one person's binging and vomiting is likely to follow a recognizable pattern; however, the symptoms also alternate with symptom-free periods, a critical fact in the solution-oriented approach. Likewise, the person experiencing chronic pain has periods of greater pain alternating with periods of less or even no pain, and factors that contribute to each of those periods can be identified and used.

So, the first implication for practice to be drawn from Rogers is to heighten our awareness of patterns and rhythms, underscored also in the work of Malinski (1986) and Barrett (1988). When we recognize clients' (and our own) patterns of living, we see that patterns are learned and reinforced by repetition. Therefore, they can be unlearned, broken, or altered and new ones created. This process, then, may be at the heart of helping people to change (Fisch, Weakland, & Segal, 1982; O'Hanlon & Weiner-Davis, 1989).

The second essential Rogerian concept states that we all have different points of view of reality and we are creating our own realities all the time, an experience Rogers refers to as the relative present (Malinski, 1986). Said another way, each person is a center of consciousness with his or her unique experience of space and time, or, even more simply, "everyone is an exception" (O'Hanlon, 1990). This emphasis on the uniqueness of the individual is in close agreement with the views and clinical approaches of Milton Erickson, whose work greatly influences the solution-oriented therapists (de Shazer, 1985; O'Hanlon, 1987; O'Hanlon & Weiner-Davis, 1989; Zeig & Gilligan, 1990). Specifically, this interpretation of Rogers and the "solutionists" insists we let go of (1) our assumptions regarding what a person will be like based on his or her pathological label, and (2) how a person should feel, think, look, and behave based on the clinician's definition of what is "healthy". In O'Hanlon's words, we must be vigilant in avoiding "hardening of the categories" (1990).

Because of the uniqueness of each person and the fact we are in continuous interaction with our environment, we live in a world of unlimited possibilities. Rogers (1970, 1987) frequently reiterates her long-held view that her ideas are optimistic, but not utopian, which this clinician interprets as meaning there are always possibilities, hope, and options. Nursing's job is to help people find the options that work best for them. Many times that process is highly influenced by the clinician's perception of clients and their situations. How we view their concerns and abilities affects goal-setting and outcomes. How we define a problem has everything to do with finding solutions.

Essential Principles From Brief, Solution-Oriented Therapy

Major proponents of the solution-oriented approach write "the key to brief therapy [is] *utilizing what clients bring with them to help them meet their needs in such a way that they can make satisfactory lives for themselves*" (de Shazer et al., 1986, p. 208). The first of three essential principles, therefore, states that the material for solutions lies with the client, and will become apparent to us when we listen and observe carefully for clues regarding client skills, strengths, and interests. Nightingale (1946) taught us long ago that this principle is also at the heart of nursing practice when she wrote,

> Pathology teaches the harm that disease has done. But it teaches nothing more. We know nothing of the principle of health, the positive of which pathology is the negative, except from observation and experience. And nothing but observation and experience will teach us the ways to maintain or to bring back the state of health (p. 74).

O'Hanlon tells a Milton Erickson anecdote that beautifully illustrates this principle. Erickson was

asked to see an elderly woman who had become increasingly more depressed, isolated, and possibly suicidal. He visited her in her home and learned that she was confined to a wheelchair and left the house only once a week to attend church services, although she had no social exchange with others in the congregation. He asked her to take him on a tour of her home, and they went from one grey, dismal room to the next, chatting all the while. Finally, they came to a room with a little more sunlight than the others and in considerably more disarray: she was in the midst of repotting cuttings from her African violet plants. As he was leaving, Erickson suggested that she continue repotting her plants, and each week take a small cutting to anyone who had the announcement of a birth, death in the family, or wedding engagement in her church bulletin. She was simply to offer them an African violet with the appropriate expression of best wishes, congratulations, or condolences. After telling his student O'Hanlon this story, Erickson showed him a yellowed newspaper clipping with the headline "African Violet Queen Dies: Mourned by Thousands." When O'Hanlon expressed his admiration but also his doubts that there was anything clinically useful to him in this intervention, Erickson replied that he had looked around her home, and the only sign of life he saw was in the African violets—so he knew the solution had to do with them (O'Hanlon & Hexum, 1990).

Further use of this technique of making links between clients' abilities and interests and the solutions to seemingly unrelated problems will be discussed under practice application. In addition, this story provides a reminder of the potential usefulness of a home visit.

A second principle of brief, solution-oriented therapy directs us to use a systems perspective in approaching client situations. Especially important are the two systemic axioms that state a change in one part of the system affects the whole system, and small changes tend to lead to other changes. In other words, change within a system has a "snowball" effect, and knowing this can help us influence change in the desired direction (O'Hanlon & Weiner-Davis, 1989). For example, a client working on an overeating problem agreed with this clinician that she would try not eating after 9 P.M. as one way to interrupt her overeating pattern. She decided she would drink whatever she liked after 9, but she would simply think of herself as someone who does not eat after that time. Two weeks later she said that not only had she stopped eating after 9, but she was surprised to find she had also lost her desire to snack between meals during the day. We decided not to question or analyze this "snowball" effect of the one intentional pattern change, and a year later she reports her healthier eating habits and weight loss have been maintained.

A third basic principle of the solution-oriented approach directs us to emphasize the future and possibilities for change instead of exploring the past and details regarding the hypothetical etiology of problems. Said another way, in therapy situations we do not necessarily need to know the cause to find solutions (O'Hanlon & Weiner-Davis, 1989). De Shazer et al. (1986) state outright that "all the therapist and client need to know is: 'how will we know when the problem is solved?' " (p. 210). This represents a dramatic departure from traditional approaches to therapy that emphasize the hypothetically causal relationship of early childhood trauma to present problems and/or in-depth analysis of the client's present problems to the exclusion of exploring existing pleasures and strengths. Fortunately, more clinicians not directly affiliated with the solution-oriented approach are beginning to question the difference between causative and maintaining variables in human dilemmas, and the clinical implications when therapists pay attention to this difference (Bishop, 1991).

PRACTICE APPLICATION

For this clinician, the essence of Rogers when applied to clinical practice involves careful attunement to the uniqueness of each person's experience and to the patterns of living that create that experience. The solution orientation then tells us what to do with the data gathered from this careful attunement; namely, let the person's uniqueness in terms of strengths and interests give us the keys to helping them solve problems, and use those patterns of living by taking actions to amplify positive ones and interrupt problematic ones. Before discussing intervention techniques, however, note that both Rogers and the solution therapists would agree that any act of assessment is also an intervention, based on what we emphasize with our attention. Assessing with an emphasis on possibilities (what is going right in someone's life) is pow-

erfully different from an emphasis on pathology (what is going wrong). With that in mind, the following four techniques are considered basic to this integrated approach: (1) establishing clear goals in language that helps promote change; (2) focusing on client strengths and skills instead of pathology; (3) refining the art of reframing; and (4) designing and implementing interventions that address patterns of living.

Establishing Goals

This first step is vital: establishing clear goals in language that reinforces that change in the desired direction is likely to occur. Going back to de Shazer's point that all we need to know is how we will know when the problem is solved, the therapist asks the client to describe in great detail what success will look, sound and feel like. For example, if someone labels his or her problem as low self-esteem, therapist and client will want to establish how the client will know when his or her self-esteem has improved. What will the client be doing? What will others notice has changed? What will be some of the early, concrete signs of improvement? O'Hanlon and Weiner-Davis (1989) give extremely useful suggestions for questioning the client along these lines, creating a clear image of what the client is aiming for.

There are many subtleties in our use of language that give opportunities to create either an atmosphere of doubt or hope that change will occur. Barrett (1988) maintains that continuous change is not only inevitable, but that it is the unifying concept in applying Rogers' ideas to practice. Often clients view themselves as "stuck" in problematic patterns to which they see no alternative, and may not even believe that change is possible. When the therapist talks in terms of "when" these changes will occur versus "if" they will occur, this can be a small but powerful way to open up hope. Likewise, when counseling a student who has failed to master a basic skill, the advisor can say, "So, you haven't learned to safely give an injection *yet,*" implying that this will be learned in the future. Using language that promotes desired change means helping clients project into a future when things will be better, even if not completely resolved. This clinician likes to think metaphorically of rolling a bottle of champagne on ice into the room during the first session—it is not uncorked yet, but it sits there for all to see that eventually there will be a celebration.

Focusing on Strengths

Rogers (1986) tells us to note the rhythmic, patterned nature of human living, and the solution therapists (de Shazer et al., 1986) say that in those rhythms we will find the spaces in between the problem that can be so useful to the client. For example, when working with someone who complains of depression, the therapist would ask, "What are the days like when you are feeling better? What are you doing on those days?" Even more specifically, this clinician asks the client to describe the best day he or she had within the last 2 weeks, and we walk through that day to find the elements that made this a better day than the rest.

Other important areas in uncovering strengths include finding out how the client has solved a similar problem in the past, and what may already be occurring that is in the direction of the desired change. Research done at the Brief Family Therapy Center indicates that between the time of the initial phone contact and first visit, most clients report some improvement in their situation (de Shazer et al., 1986).

Often, the most useful action the therapist can take is to help the client make a link between what they do well and how to solve their complaint, even if the two seem to have no apparent connection. For example, a young woman came for therapy saying she did not know how to handle her anger and that this was an obstacle to having satisfying relationships. She revealed that the greatest source of success and happiness in her life had been her involvement in athletics several years before, but she had drifted away from that. This clinician suggested that possibly one of the benefits from sports was that it gave her an arena to "blow off steam," and wondered what would happen when she got reinvolved in such activity. The young woman enthusiastically rekindled this old flame, and reported improvement in those areas for which she sought help.

When therapy focuses on where clients have been successful instead of the details regarding how, why, and where they had failed, a transformation and vision for success takes place more

easily, and they will come up with their own ideas for possible solutions.

Reframing

The concept of reframing—offering another explanation of the problem that fits the facts but makes the problem more solvable—has been useful in the family therapy field for many years (Minuchin & Fishman, 1981; Satir & Baldwin, 1983). Rogers (1987) refers to the different ways we frame or interpret behavior when she points out that we call an 18-year-old who goes outside in the middle of the night to see the moon "romantic," whereas an 80-year-old who does the same thing is "senile." The art of reframing in the counseling context involves giving the client a different point of view that helps him or her formulate new ideas for action, as seen in the following examples.

A student advisee came to this clinician's office stating she had been "devastated" by feeling "attacked" by her fellow students in a seminar earlier that week. She complained for about 20 minutes, asserting she would never return to that class, would probably drop out of school, would definitely go to the dean to file a complaint, and so on. After listening to her and acknowledging how upsetting this experience was, the following response was offered: "It sounds to me like your peers see you as strong enough to handle confrontation, and that you also want them to see you have a vulnerable side and can be hurt. I'm curious about how you will get them to see that." The student instantly sighed, relaxed, sat back in her chair and answered, "Yes, and what hurt the most is that this is my favorite class." She proceeded to describe how she wanted to address the situation in class next time, which she did with successful results. After careful listening and a simple but plausible reframe, she came up with her own solution.

In another case, a woman was separating from her husband by her own choice, uncertain regarding the eventual outcome of the marriage, but having difficulty tending to her own needs for rest, relaxation, and nourishment during this time. This therapist started referring to the separation period as a "vacation" from her husband, and asked her what she usually does to care for herself, to have fun, and to treat herself specially while on vacation. It was then easier for the client to describe "vacation" activities she enjoys and follow through on plans to do them.

Reframing is a valuable step in a variety of contexts, and there are many examples of using reframes effectively. Link (1991) describes a stress management program for military personnel strategically titled a "Mental Toughness Program" to give a frame of reference more agreeable to this group. However, it is important that the clinician avoid using reframing to minimize the person's struggles; the process includes acknowledging clients' pain and difficulty, and then helping them focus on how to move forward.

Pattern Interventions

The term "pattern interventions" was first applied to a Milton Erickson technique (O'Hanlon, 1987), pattern interventions involve finding ways to use positive patterns, establish new ones, and interrupt problematic ones to facilitate attainment of client goals. From a Rogerian perspective, it is a logical intervention technique once some of the client's patterns of living have been made clear.

First, the therapist wants to learn about the positive patterns of living and how they can help in solving the problem. In other words, what are the African violets—the sparks that make life worth living—for this person, and how can they be put to use? O'Hanlon and Weiner-Davis (1989) describe a first-session technique where therapist asks client to go home and notice everything that is happening in his or her life the client would like to have continue, and be able to describe this in detail the next session. This gives valuable information for possible solutions as well as redirecting attention to what is actually going well.

When interrupting problematic patterns, one looks for a small "monkey wrench" that can be tossed in to disrupt the usual predictable course of the problem. de Shazer (1985) suggests that when some response to a problem is not working, one should do something, anything different. Some examples of pattern interruption follow.

A client with an "almost lifelong eating disorder" sought treatment. It was learned her unique pattern of binging involved grazing on high-fat foods throughout the day, especially at work. This therapist suggested she bring bags of cut celery with her to work; the client no doubt expected to be told to substitute the celery for her binge food.

However, the pattern intervention went like this, "Whenever you want a donut, for example, go ahead and eat it, and then eat five stalks of celery as well." The client, amazed, agreed to try this and reported weeks later that she only had to use the celery once, stating, "whenever I wanted to eat something fattening and thought about having the celery too, it took all the fun out of it." This, of course, is similar to Haley's (1984) ordeal therapy, with the idea of prescribing something that makes it harder for the symptom to continue.

In a different type of pattern interruption, a graduate nurse practitioner student sought supervision in counseling a client who became increasingly more anxious during his working day as a bank officer, until he was terribly uncomfortable and low-functioning by the end of the day. Medication had not been of much help and she wondered what else he could try. It was asked if he juggled, because it is quite impossible to juggle and be tense at the same time, or if there were some other similar activity he enjoyed. The bewildered student left wondering if her instructor had lost her marbles, but returned happily to report success. She had learned on the client's next visit that he had thoroughly enjoyed hitting a ball attached to a paddle as a child, loved to see how many times he could hit it, and still had one somewhere in his garage. They agreed that he would try taking it to work and whenever possible, take a 5-minute break each hour playing his favorite childhood game. "He loved the idea!" she exclaimed.

In a recent study on sleep pattern disturbances (Elliot, Gillins, & Rogers, 1991) researchers reported the unexpected findings that two of their subjects had ended 20 years of sleep problems simply by eliminating the one cup of coffee they regularly drank daily for breakfast. The study focused on substances that interfere with sleep, and the investigators felt it was highly unlikely that such a small dose of caffeine so early in the day could be the culprit. An alternate interpretation is simply that the interruption of routine made the desired change possible.

CONCLUSION

Although the basic techniques have been presented, there are many additional techniques that draw on client and therapist resourcefulness and creativity. Use of storytelling, metaphor, guided imagery, symbols, and task assignments are very effective, and detailed in several excellent books (De Shazer, 1985; O'Hanlon & Weiner-Davis, 1989; Zeig & Gilligan, 1990). *In Search of Solutions* by O'Hanlon and Weiner-Davis (1989) is highly recommended as a readable, "how-to" primer on solution-oriented therapy, with suggestions that an experienced therapist can easily incorporate into practice.

Integrating this approach with nursing theory and practice provides many potential clinical uses beyond psychotherapy. Teaching communication skills to baccalaureate students means showing them how to use client strengths, not simply that it is important to identify them. These students in the inpatient psychiatric setting brought a new perspective to staff and patients alike with their heightened interest in highest previous level of functioning and action-oriented goals, even as they increased their knowledge of psychopathology. Family nurse practitioners have numerous opportunities to counsel clients; clinical specialists in community health and other areas can find an integrated solution-oriented approach useful as well. As long as nursing is about solving human problems, attention to patterns of living and the resources held within the client's grasp will increase our effectiveness and creativity as clinicians.

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