Brief Solution Focused Therapy in Ukraine to Work with People with Emotional, Cognitive and Behavioural Disorders

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Abstract

Aim. To study the way how Brief Solution Focused Therapy (BSFT) tackles emotional, cognitive and behavioural disorders. To provide basic definitions of such disorders and identify major approaches and techniques focusing on Brief Solution Focused Therapy aspects that may be applied in psychotherapeutic works with these people.

Methods. Ana\lysis and synthesis of scientific data regarding defining emotional, cognitive and behavioural disorders. Distinguishing basic diagnostic signs of such disorders in clients. Methods of BSFT psychotherapy.

Results. The following BSFT techniques proved to be the most effective in the work on emotional disorders: *problem-free talk*, *compliments*, *resource questions* and *scaling*. These techniques can be called the most *emotional* ones – the techniques that call for your emotions, replenish your psychological resource, help rebuild your emotional attitude to the situation, look at it from a different angle. BSFT-based psycho-correction and psychotherapy of cognitive impairments and behavioural disorders is longer and more fundamental. Effective techniques are goal setting, resource identification, and also there are special turning points, such as the technique of life analysis, which is a variant of *scaling as a method*, use of *coping questions.*

Conclusions. BSFT-methods are effective in addressing different disorders – both partial (emotional, behavioural, cognitive) and more complex ones. The fact that BSFT does not focus on the negative emotional conditions, the problem and its causes, enables the depressive clients, grieving clients and clients experiencing loss to relatively fast discover their resources and start building plans, demonstrating how it is possible to optimize the process of overcoming complicated life situations.

Keywords. Brief Solution Focused Therapy, emotional disorders, cognitive impairments, behavioural disorders, people with disabilities

Introduction

One of the most effective modern ways of this assistance is short-term therapy or Brief Solution Focused Therapy. This method originated in the USA, it was founded by Steve de Shazer and Insoo Kim Berg (de Shazer et al., 2021). Since the 1990's this method has gained worldwide popularity (Trepper et al., 2006). In Ukraine this method has become known due to the efforts of the Polish Centre for Short-Term Therapy (Centrum Terapii Krótkoterminowej) and its leaders Jacek Lelonkiewicz and Mariola Lelonkiewicz (Lelonkiewicz & Lelonkiewicz, 1997).

The main idea of the method lies in shifting the focus from the problem onto its solution, which should not necessarily be related to the problem (Kim, 2014). In a psychotherapeutic relationship the client is at the same level as psychotherapist and becomes a co-therapist, an expert in a therapeutic process. Such a vision of the client's role enables him/her to concentrate on resources and means leading to successful problem resolution. The conscientiousness of the client is changing regarding his/her understanding of his/her influence on his/her life. It enables the client to build his/

her own motivation – set goals, find resources for their achievement and, finally, achieve his/her personal goals.

The advantage of the therapy lies in the fact that the therapist need not have good knowledge of the problem and understand it. Problem analysis is replaced with the best optimal solution. The role of expert in his/her own life, given to the client, enables him/her to build an optimal and quick psychotherapeutic process.

The ultimate philosophy of the short-term therapy is based on three points: "Do not repair it if it's not broken"; "If you already know what to do – do it, repeat it"; "If it does not work – do not do this, do something different" (Lelonkiewicz, 1997). In this way the emphasis is shifted to the healthy behaviour of a client engaging cognitive and behavioural aspects.

A lot of attention is paid to proper and optimal goal setting (Bannink, 2010). There are the following signs of well-formulated goals in BSFT: visible for clients; better small than big; clearly described; related to behaviour; described as "beginning" and not the "end" of something; described as "availability" and not as "absence" of something; real and achievable for client.

Let us consider the ways BSFT addresses emotional, cognitive and behavioural disorders. Referring to the notions of emotional, cognitive and behavioural disorders in Ukrainian psychological science it should be noted that they are mainly researched in two directions – medical and correctional ones. The medical direction exclusively relies on nosology classification, based on ICD-10, and is not related to psychological aspects of this issue. The correctional approach is represented by special pedagogy and psychology. However, the majority of scholars here also focus solely on disorders having organic origin, moreover, these disorders are studied in age-related aspect, i.e. as certain manifestations in children and teenagers.

Therefore, we primarily focus on the adult population. Apart from this, we concentrate not on serious nosology deviations, but on disorders that allow the person to fit into society and can be addressed with psychotherapeutic methods.

Work with Emotional Disorders in BSFT

It is necessary to consider how these disorders are understood in modern Ukrainian psychology. If we refer to the idea of emotional disorders, there are similar approaches to their understanding, which conditionally categorise these disorders into two subtypes. Some disorders are related to the conditions of agitation, while others, on the contrary – to the states of inhibition. The first subtype manifests itself in expansiveness, irritation leading to, according to Iryna Lysenkova, conflicts and activity disorganisation. The second subtype is characterised by the distressed condition with depressive manifestations, accompanied by low self-evaluation and lack of

self-confidence (Lysenkova, 2018). A similar idea is offered by Valentyna Voitko, indicating that emotional disorders manifest in two types of behaviour – agitative state where expansiveness, irritation, aggression prevails, and depressive state which is characterised by quick fatigue, anxiety, indecisiveness (Voitko, 2016).

According to Anhelina Tereshchuk, the changes mainly lead to severe depressive disorder in the form of depression or maniac-like mood improvement, there are changes in intellectual and motor activity of the brain. At the same time emotions stop performing their function of reality evaluation. Mood fluctuations result in changes of energy and activity levels. Mood disorders are frequently combined with other mental impairments: most frequently with anxiety disorders, addictions and other personality disorders (Tereshchuk, 2019). Later affective disorders can lead to disadaptation, i.e. loss of ability to adjust to reality. Other negative consequences of emotional disorders can be suicide and self-injury behaviour, psychosomatic behaviour, drug abuse, etc. (Mateiko, 2017).

Affective disorder is insidious as it results in long-lasting inability to work during acute conditions and intellect preservation, which makes functioning of the individual even more complicated due to his/her incapacity in many fields, and this, in its turn, causes even more depressive states (Tereshchuk, 2019). As we see, in many cases this type of disorders is associated with emotional instability at the background of broken social connections.

Psychotherapy (individual, group, family), as one of the important methods in affective disorders, is used to reduce communication issues in depressive disorders and presupposes certain stages, namely: becoming aware of the problem and establishing emotional contact; detecting disadaptive thoughts that support disappointment, distress; positive motivation (human emotions and behaviour are closely related to the evaluation of the surrounding world) and optimal behaviour that should lead to positive internal changes (Tereshchuk, 2019).

Depression, as the state of low mood and aversion to activity influences cognitive, behavioural and emotional functions of a person. Being a peculiarity of mental syndromes, for example, deep depressive disorder, it can also be a response to certain life events, for example, such as loss of a loved one, severe disease, drug addiction, etc. Depression causes drastic changes in the life of a person with regard to his/her previous life. This change manifests itself in depressive mood, loss of interest in life and life satisfaction, causing significant distress and impairments in personal, social, professional and other important areas of human life. People with depression feel sadness, despair and internal emptiness, suffer from insomnia and loss of energy, they have reduced cognitive abilities and concentration, they evaluate themselves as worthless and guilty and they often have suicidal thoughts.

While working with depression traditional psychotherapies primarily address the issue of reducing its negative impact. Brief Solution Focused

Therapy (BSFT) focuses on enhancing positive influence to assist the clients with improving the quality of their life (Bannink, 2015).

Let us consider psychotherapeutic cases illustrating use of Brief Solution Focused Therapy with such a client. A 26-years-old girl called asking for therapy. Her request was to work with apathy and lack of motivation to life and work, fear of cooperating with other people, sleep problems and not being able to have a good rest, constant exhaustion. At the end of the talk she was offered to think, prior to the next therapeutic session, about the changes she expects after the therapy. During the first session problem-free talk became intertwined with negative description of her condition by the client. On the one hand, the client was clear about the resources she used to cope with the situation she was in (her boyfriend, friends, communication with them, which is a great support for her, but very often she has neither strength, nor desire for this), and on the other hand, she was worried about the depressive state, which, in her opinion, she was in.

When asked what were the changes in her life that made her ask for psychotherapeutic help, she answered that she was seriously worried about herself, her apathic state she was constantly in, lack of strength to do any work, bad sleep, in particular – problems with getting to sleep, and later – with long-lasting sleep which does not bring any recovery.

Then the client referred to the telephone discussion, particularly, to the changes she expected, and said she wanted to improve her health, get rid of depression, she wanted to work, study, have a personal life. And the condition she was in did not give her any hope for the better, she is at a loss and she feels terrified.

When asked whether the condition she was in is a new experience in her life, she answered that she had already been diagnosed with clinical depression and had psychiatric treatment. She added at once that she was also considering a visit to a doctor, but first of all she wanted to ask me for advice as her previous experience of psychiatric treatment turned out to be traumatic for her. A psychotherapist asked her whether he understood her correctly that she had the idea of cooperation between a psychotherapist and a psychiatrist in psychotherapeutic work with her. She confirmed that these were her expectations at that time and asked for the information about the psychiatrist working in cooperation with a psychotherapist, to arrange a visit to a former.

To the psychotherapist's next question "What changes would this cooperation bring to her life?", she answered that she had experience of pharmaceutical support during her previous depressive state, and understood that it was necessary, but stated that that support was not enough, therefore, she was of the opinion that she needed psychotherapy.

When asked what step should be the first one in her work on herself the client replied that she would probably go to the doctor I recommended and start treatment if it were necessary. The client was offered testing based on Beck Depression Inventory which showed high depression level, and she

was even more convinced she needed to go to the doctor and get pharmacological support. The home task of the client (according to BSFT approach, one can either do it or not) was to think over and describe her personal internal resources, as well as external ones (people who can provide support and places that provide recovery).

At the next session answering the question what changes happened in her life since the previous session the client said she went to see the psychiatrist and she was prescribed pharmacological therapy. She said she started taking medications and she seemed to feel better, anxiety level dropped, she slept better and seemed to have more energy. The client wanted to discuss her home task, as, according to her, she did not cope well with it. The only real resource she saw was her boyfriend, who did not criticise her but was supporting towards her. When asked by the therapist what could be other ways of using that resource, she took her time to think and said: "I should talk to him more often". To the follow-up question of the therapist what new things could be done or changed in their relationship, she said that at that moment she should be more responsive to his attempts to contact her as she often ignored them.

The client was offered *scaling technique* that enables the client to concentrate on client's life changes on his/her way to the desired future (Ratner et al., 2017). *Scaling* as a technique is also used in problem-oriented therapies, where scales such as the Beck Depression Scale, the Spielberger-Khanin Anxiety Scale, or the Subjective Distress Unit (SUD) scale show the peak of the problem in their highest point and zero of the scale is a place where the problem does not exist. In Brief Solution Focused Therapy rapy there is a radical change – 10 (the highest score) means the desired future of the client, 0 or 1 – the worst that it can be (Bannink, 2015). When asked by the therapist where on the scale between 10 and 1 the client could place herself, where 10 is the best possible communication between her and her boyfriend, and 1 is the worst possible, she said after a short pause that it was 3. Describing the place on the scale where the client placed herself, she pointed out that she was doing better at making herself answer calls and messages of her boyfriend on social media. However, she does not always succeed in doing it due to lack of internal resources. When asked what she could change to take a step forward from 3 to 4, she thought that it might be good if she took the initiative and called or wrote to him from time to time. Later, she suggested a step, which, in her opinion, she could possibly take, which was calling or writing to the guy once a day in the evening. For homework the client was asked to think about other opportunities to communicate with her boyfriend and people who were close and important to her. Thus, BSFT helps quickly, in the case of a depressive client, identifies the resource and makes this resource work.

Another area of psychotherapeutic work with emotional disorders is work with loss. There are many theories in the scientific literature that describe the grieving process and the stages a person lives through when

they experience loss and grief, namely: the four tasks of grief by James William Worden (2018), the five stages of grief by Elisabeth Kubler-Ross (Kubler-Ross & Kessler, 2005), attachment theory by Richard Bowlby (Bowlby & King, 2004), etc. They help structure the experiencing process, as well as allow the client and psychotherapist to understand the stages of going through loss and grief.

When working with people who are grieving the loss (death) of a loved one, a psychotherapist needs to take a complex approach to the situation, considering each individual case separately. According to Elizabeth Doughty and Wendy Hoskins, a person experiencing loss is influenced by a number of factors, including age, experience, individual peculiarities, life values, and social and religious beliefs (2011). Each of these experiences has an undeniable impact on the grieving process. And it is due to this that the course of grieving includes a natural "normal" response to loss, based on basic and individual differences.

Brief Solution Focused Therapy, in its basic approach, does not require immersion in the problem and its in-depth study. Thus, it allows the client to determine, together with the therapist, the depth of these experiences. Such a tandem ensures that cooperation is positively dynamic, has no traumatic consequences, is consciously and logically completed for the client, because it is the client who acts as an expert in his/her life and is responsible for his/her decisions (Isebaert, 2017).

Let us consider a psychotherapeutic case demonstrating application of these BSFT principles in practice. Client M., a 32-year-old woman, at that time was grieving the loss of one of her parents, namely her mother. According to M., she lost the sense of life, felt betrayal on the part of her loved ones and disappointment in family and generally human values. As her mom was ill for a long period of time and it was the client who had been doing the household chores and looking after her seriously ill mother, she felt devastated and exhausted after her mother's death. The main objective of the session was voiced by the client as "… to do something to feel less pain, stop feeling guilty and stop crying… Find sense of life and the possibilities to continue living without the loved one".

The client had three 50-minute psychotherapeutic sessions. At the end of each meeting she was offered a home task, which the client did. At the end of the third meeting, according to the client, her goal was met, and while doing her home task she made a list of tasks she called "action plan for the year".

During the *problem-free talk* at the first meeting M. was always depressed and was crying all the time. Going from chaotic remembrances of pleasant memories of the past, where her mother was alive, the client evaluated her relationship with her father and her brothers as happy ones. Talking about this during the sessions, she paid attention to some tension in family relationships and to the fact she was not always able to control her feelings. Grief and disappointment turned into despair and low spirits. The

client interpreted the situation as such that "does not have any future". She indicated that it was impossible to establish further relationship with her family.

During the session a lot of time was spent on discussing with the client the way she lives through her loss and attention was given to this issue. Talking about "exceptions from the problem" every time M. was more active and positive while describing family relationship and her desire to make up for the time lost, as after her mother's death her relatives stopped communicating with her. Reflections about possible development of the events in case the client changed her attitude to her family members inspired her to think about further changes in the situation. Trying to find *resources* in that situation and answering the question what helped her and inspired her to move forward, the client answered it was "memory about her mother", as she would not like to upset her mom because of these quarrels. The compliments to the client on her courage and strength of mind improved her condition, she was visually calmer, her voice stopped being shaky, she stopped crying. The client made the decision to build the dialogue with all family members. The home task which client M. identified to herself was to take the first step to reconciliation with her family, relying on the understanding that under such circumstances the relationships are possible.

The second and the third sessions discussed the hometasks and changes in the client's life she wanted to share. There was also reinforcement of the result achieved as the client established contact with her relatives and needed support. At the third (final) session M. was able to talk about the loss of her mother and relationships with her relatives freely, calmly, seeing prospects for the future.

One of the most frequently used tools in Brief Solution Focused Therapy was the *scaling* method used to describe the client's condition "here and now", where the scale of 0 is the worst condition and 10 is the best. In working with the client, this tool was used at all the sessions, however, according to the client, the first two were not perceived by her as effective. During the third meeting, at the client's initiative, the *scaling* was used to assess each item on the list of things that needed to be done. At this stage, the client chose to use *scaling* as a description of improving and changing her life from where she was on the day of psychotherapy, to the desired and real future.

This example clearly demonstrates one of the key points of BSFT – it is the client who best knows what can help him/her and it is the client who is the best expert of his/her condition and life (Ratner et al., 2017). The client's ability to keep his/her life and even psychotherapy under control will make him/her stronger and more confident. Thus, using BSFT methods to help the client find resources and build plans for a relatively short period of time, as for the grievance stage, illustrates how it is possible to optimise the process of overcoming loss.

Work with Cognitive Impairments in BSFT

Ukrainian researchers attribute cognitive impairment to a malfunctioning of one or more cognitive processes, usually attention and memory. If perception and thinking are also involved, then one is talking about deeper impairments. According to Natalia Svyrydova (2019), in the medical field, these impairments are clearly differentiated as to their degree and scope of manifestation.

Oksana Kopchak (2017) argues that cognitive impairment is a decrease in one or more of the following cognitive functions: memory, praxis, gnosis, speech, or executive functions compared to the individual's norm. The severity of cognitive impairments can range from mild, which are associated with the natural aging of nervous tissue and are considered the age-related norm, to the most severe form of cognitive impairment, including dementia.

In the opinion of Liubov Milevska-Vovchuk (2016), cognitive impairments manifest themselves in slower mental processes, decrease in attention, memory, cognitive flexibility. Also there are impairments in categorisation, generalisation, abstract thinking, planning, regulation and activity control, behavioural impairments with impulsiveness, emotional lability, disinhibition, reduced criticism, aspontaneity.

Such impairments are also considered by the scholars in combination with behavioural and emotional disorders. For example, Viktor Synyov et al. (2019) consider psychological peculiarities of children and teenagers with intellectual impairments that have aggressive, conflict-oriented, victim, offending behaviour. They also analysed peculiarities of emotional development and violation of the emotional field of junior schoolchildren with intellectual incapacity.

Let us consider how Brief Solution Focused Therapy works with different types of impairments in real psychotherapeutic cases. Client K., 27 years old, single, in relationship, drug addict in remission state, undergoes rehabilitation. During therapy he was living with his father and was partially financially dependent on him, as K.'s personal earnings did not cover all his needs.

He came to the psychotherapist with a self-identification request, as well as his professional identity. Self-identification is impaired, as he cannot clearly identify his I, which in client's opinion, could double, triple, when "many I have their dialogue in the head". Professional self-identification is related to the goal to get high financial income. He was demonstrating the desire "to get everything now", without taking any particular efforts. The client has higher education, was working in many fields, mainly in the Humanities. He likes those activities which require interaction with people and skills related to influencing people. Here one can trace client's inclination to manipulation. At the same time, he does not feel independent and mature as to his age. He has been living with his mother for a long period

of time, but recently he has moved to his father, who lives in a different city. The client positions himself as a person who is quite well-read and knowledgeable, but cannot integrate and use all this knowledge.

At the background of this situation there are certain emotional and behavioural problems, related to fears and loss of self-control, as well as cognitive problems, manifesting themselves in worsening of memory, and related, in client's opinion, to taking medications during drug addiction treatment. Although one cannot rule out that such impairments appeared because of drug addiction.

All in all, there were 6 meetings on using Brief Solution Focused Therapy techniques. Client's resources were his relationship with his close surrounding, in particular his girlfriend and friends. Also among the resources he named was the feeling of victory from his personal achievements, for example, in the educational field, as now he was studying trying to master a new job. Another resource particularly stressed by the client was the ability to predict the actions of other people and influence them.

The first formulated goal was to learn to make a choice, as he appeared to be at a loss in the situations when it is necessary to make a choice and, consequently, did not make any choice at all. This goal was related to the boost of his self-evaluation, which was specified as the following: to do something good for one's health. Another goal that was specified at the next session was to work in a team on the managing and teaching positions (called this position "Coach").

With this client the technique was used which conditionally may be called *Scaling as a method*. During this technique the client's life was processed with respect to achieving the status of a Coach. In the conversation the client expressed the idea that this status could be described with the word "Experience", and his life – "Search for the new experience". The client clearly described his every step, however, during the second session he was talking a lot about his past, in particular, about his studies at university, the starting point of addiction, treatment and rehabilitation period.

When the technique *a miracle question* was used, he was not able to specify his behaviour in case the problem disappears. His answers were very superficial and could not be extended. The leading questions were used about the relationship with other people, when the issue about conflict orientation and aggressiveness of the client was raised, which, if suppressed, turned into autoaggression. At the same time, he was contrasting himself with his father, who, in his opinion, avoided conflicts. Also the emotion issue was raised, as in real life he did not get such emotions which he had when he had used substances or had been playing games. Several times he had an idea about "expecting some miracle in life which does not happen". He devalues positive moments of his everyday life, for example, nice surprise gifts from his girlfriend.

At the beginning of the therapy the client was very diligent regarding doing all the home tasks, writing down everything that happened to him.

However, during the next sessions the novelty effect disappeared, which resulted in the decrease in the positive attitude to the therapy, devaluation of positive moments and no home tasks done.

At the following sessions when *scaling as a method* technique was used, it was possible to outline 10 stages on the way to his goal, determine the current position of the client on this conditional scale and identify the first step to make to go from one stage to the next one. This first step was about a certain attitude to life events, certain behaviour on the way to his goal, and even certain specification regarding his work on his appearance, his success with his studies and job options. Among the actions offered only priority ones, in terms of implementation, were chosen. The therapy was over.

Therapy discussion: despite high emotionality and imbalance of the client, presence of certain cognitive and behavioural disorders, propensity to manipulation, we managed to outline specific psychotherapeutic goals, identify opportunities and resources of the client to implement them and specify them in the form of the "first step". Of great use here were the constructive questions, which were not about the social relations, but the inner world of the client, his aspirations and motives, which were initially contradictory. The client's attitude to therapy was changing during the course of the therapy: from euphoric and unrealistic at the beginning, to devaluing in the middle and positive and practical at the end. The positive attitude was supported by the simplicity and concretisation of actions to achieve the goal. Such steps in working with addicts are quite effective, which was also stressed by other psychotherapists (Lelonkiewicz, 1993).

Working with Behavioural Disorders in BSFT

In modern psychological science there is no single approach to the definition and classification of behavioural disorders. According to Sofiia Berezka, in modern science behavioural disorders are studied in terms of two opposite approaches – biological and psychological, social and pedagogical. Consideration of behavioural disorders as a separate nosological unit (biological approach) limits the activities of psychologists in psycho-correctional and psycho-diagnostic work, as it defines behavioural disorders as a disease that is beyond the competence of the psychologist. In its turn, the psychological and socio-pedagogical approach examines behavioural disorders as types of behaviour that deviate from the norm (but are not pathology), and the decisive factor in their development is the social environment and mental development of the child (Berezka, 2018). Thus, behavioural disorders are a set of systematic generalised deviations in behaviour, characterised by a stable inability to control one's own behaviour with respect to the established social norms and lead to disruption of daily functioning of the individual (Berezka, 2018).

Behavioural disorder may be caused by psychotrauma, and touch upon not only the external behavioural layer, but also the internal personality layers. It is evident that the degree of severity and intensity of psychotrauma will be of utmost importance. In psychotherapeutic practice it is the psychotrauma that is the most frequent reason for the visit and it requires very thorough, often long-term work not only on the behavioural, but also emotional and personal aspects.

BSFT also proved to be effective with behavioural problems of people with disabilities. The key BSFT directions in the work with people with disabilities are: (a) focusing of the desired future of the client, (b) client's strengths and resources, (c) changes in behaviour.

There are the following basic working principles for people with disabilities with particular attention to consequences (de Shazer, 1982) in BSFT model. BSFT is known for the fact that it uses only those areas mentioned by the clients as problematic, so to achieve it and make it more beneficial for the client the talk should be based on the principle: "Do not repair, if it is not broken". There is no need to interfere into those areas, which were not mentioned by the client as problematic (especially the client with special needs). The psychotherapist should not consider the very disability to be the reason for therapy request. As a rule, the client indicates himself/herself whether disability is related to the problem in question. Considering the fact that people with disabilities have frequently been marginalised in many cultures, severity of the problem is partially due to disability. As a rule, BSFT experts preliminary consider with the client different areas of life to enable him/her to think and discuss how disability affects the problem that requires therapeutic interference.

Secondly, there is a rule that only the client is considered to be the expert of his/her life. It is of particular importance with respect to the clients with disability (Roeden et al., 2009). The clinical psychologists cannot know what was the clients' life, what difficulties or challenges they faced, how they overcame them, or how the clients coped with their disease or disability. Focusing on changing the behaviour of people with disabilities also proved to be an efficient strategy to prevent further morbidity and mortality. It is also effective to concentrate on the desired future of the client, strengths and resources, positive behavioural changes (Peter & Kim Berg, 2007).

Effective techniques in working with people with disabilities, special needs and somatic diseases: (a) wondering how they managed to deal with these problems; b) focusing on the overcoming aspect, the clients can recognise their strengths and abilities; (c) question about the desired future, even if the health will be the same; (d) maintaining focus on the future, discussing the real impact their disability could have on their progress to the desired future.

The solution is not necessarily directly related to the issue of disability. It is more likely that their solution or potential change driver will be some-

thing different from "I will be treated". There can be examples of alternative solutions, not related to the disability issue, such as: "I get on better with my partner", "I think I have a rewarding and fully-fledged job", "I find time for myself", "I have enough sleep at night".

The counsellor should be careful not to assume that disability or disease of the client should be treated for the client to feel benefits of the therapy. Once again, the clients may present any problems and the solutions to them will not have anything to do with the client's disability status.

There is no problem that lasts for ever; there are always exceptions that can be used (de Shazer, 1982). It is important to mention it, especially to clients with special needs, as these people may have tunnel vision and notice only how their impairments affect their life. It is necessary to help clients see the solutions, or time, when they coped better, or when their disability did not prevent them from achieving success. These are crucial issues for hope and joint planning of the desired future. When the clients independently are able to identify exceptions to the problems, they can get better at evaluating their strengths and abilities.

Clients with disabilities, as all the clients, have competences and resources necessary for them to achieve success or required changes (Roeden et al., 2009). Moreover, it is possible to consider any past successes mentioned by the client, exceptions (when the problem did not exist) or any ideas that may become useful.

The indisputable strength of people with diseases or impairments is that each of them was to some extent successful in overcoming the circumstances. A person may not be satisfied with the level of resolving the problem, but the very fact that a person came to the consultation proves that he/she somehow coped. When applying BSFT for people with disabilities it is important to recognise and emphasise this situation and clarify with the client what made this level of overcoming manageable.

Client O., 32 years old. A year ago she became a person with disability as she had a spine hernia and progressive prolapse of invertebral discs. There was severe pain syndrome, she had to spend most of the time in a horizontal position, mainly lying down. There was surgery on the horizon, but full recovery was unlikely. She was married, had two children 6 and 4 years old. Her husband had a job, it was his own business. O. was also an entrepreneur in the past, but was out of work for the past 3 years, as her business was not in demand anymore. Some time after the second childbirth, she had some problems at the background of aggravation of previous spine injuries. Therapy request – her relationship with her husband and his mother, bitter feelings towards them, jealousy. The first meetings with the client were offline, her husband brought her over in a car. During the consultation the client was lying on the sofa or special folding cot brought by her husband. Her husband is a busy man and is irritated due to the fact that he has to spend time on driving his wife somewhere. This is the reason why the following meetings were online.

It should be stated that the issue of chronic disease is not mentioned in O.'s request. Basic BSFT methodologies proved to be effective and became crucial in the course of the therapy. These are (a) questions about resources ("What positive things do you currently have in your life?"); (b) the question about the goal of working with a psychotherapist; (c) the question about the exception to the situation.

When asked about the resources, O. mentioned a lot of positive things and stated that even the disease had some positive consequences, as she may not do the household chores (cooking and cleaning), something she did not like doing. Now the chores are done by her mother-in-law. It was a discovery for O. that generally her life was good and she was satisfied with everything but her mother-in-law.

When asked about the goal, O. realised that if she let her mother-in-law come back to Kyiv and hire an assistant, she would not be jealous of her husband's feeling to his mother. It would be a very positive outcome for the client.

The questions about exceptions to the situations made O. remember the situations when she was not bitter about her husband. This was the period when she was financially independent, had her own earnings and did not have to ask her husband for money. Her husband also liked her independence. This thought motivated O. to have successful treatment; find a job irrespective of the condition of her health, even if she would not get better; restructure financial relations in the family in such a way that her husband would give her the necessary amount of money once a month for her to be able to spend this money, and not ask for money every time on things, which her husband considered unnecessary and good for nothing.

Conclusions

The most effective in the work with emotional disorders were BSFT techniques *problem-free talk*, *compliments*, *resource question* and *scaling*. These techniques can be called the most *emotional* – the ones that call for your emotions, replenish your psychological resource, help rebuild your emotional attitude to the situation, look at it from a different angle. In comparison with the other types of disorder, such clients relatively quickly *discover the resource* with the help of BSFT techniques. One can assume that at the moment of coming to the psychotherapist they are, to some extent, ready to go out of the emotionally negative state, as they have already done something on their way to problem resolution – they came to consultation.

One of the basic BSFT postulates, which is effective for such clients, sounds that it is the client who knows best what he/she currently needs and it is the client who is the most competent expert in his/her condition. The ability of the client to manage his/her own life and even psychotherapy

makes him/her stronger and more confident because it is also a resource. Ignoring negative emotions in BSFT approach enables the clients with emotional problems, with respect to correctional approach, to improve relatively quickly, and as regards the state of grievance and depression, discover the resource and start building plans showing how one can optimise the process of overcoming loss.

Cognitive impairments of people with preserved intelligence, inorganic genesis, rarely occur in isolation. Mostly they are combined with behavioural ones that become leading symptoms, or with emotional ones that are present in one way or another. Cognitive impairments can be the result of emotional disorders such as inhibition, attention disorders, memory disorders, such as in depressive or anxious conditions. Cognitive inhibition, disorganisation of cognitive processes may be caused by behavioural disorders – drug use, alcohol, gambling, intoxication caused by toxic and / or psychoactive substances.

It is for these reasons that psycho-correction and psychotherapy of cognitive and behavioural disorders following the BSFT method takes more time and is more fundamental. Effective techniques are goal setting, resource identification, and also there are special turning points, such as the technique of life analysis, which is a variant of *scaling as a method*, the use of *building questions* that relate to social relations and / or inner world of the client, depending on the fact which field is less developed. This approach offers a person a holistic view of life, brings the client to new meanings, reveals new priorities, which gives him/her a sense of change, renewal of life, transformation of self and situation. If these meanings can be concretised in a behavioural context, the client can see the consequences of changes in behaviour, form new habits. Thanks to the BSFT approach, behaviour becomes more structured and goal-oriented.

In working with people with disabilities and somatic diseases the main diagnosis is of importance and its impact on the ability to move, have social contacts, be professionally capable, its influence on the organisation of lifestyle, subjective perception of the disease. Depending on these aspects, there are disorders that can be classified as emotional, cognitive or behavioural. Usually there is a complex problem. It usually requires long-term work and a special approach offered by the BSFT method – from a more optimistic one, aimed at isolating the positive things in life (resource), to a more *realistic* option – *helping to survive* in such a difficult situation (it is also a resource).

Effective methods of psycho-correctional work in the BSFT method with people with disabilities, special needs and somatic diseases are as follows: (a) work with resources – question how they managed to cope with these problems; (b) acknowledgement of their strengths and abilities; (c) questions about the desired future, even if their health will not be different; (d) focusing on the desired future, discussing the real impact their disability may have on their moving forward to their future.

Therefore, the methods of Brief Solution Focused Psychotherapy and Psycho-Correction are effective in dealing with various disorders – both partial (emotional, behavioural, cognitive) and more complex (emotional, behavioural, cognitive combined), which take place in working with people with disabilities, special needs and somatic diseases.

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