Reviews

RESEARCH REVIEWS

Brief Descriptions and reflections on recent research articles and books relevant to the development of Solution Focused practice and theory.

By Dave Hawkes

Comparing two research papers on training in SFBT: Is more better?

Smith, I. C. (2011).

A qualitative investigation into the effects of brief training in solution-focused therapy in a social work team.

Psychology and Psychotherapy: Theory, Research and Practice (2011).

Pp 335–348. British Psychological Society. Also available at www.wileyonlinelibrary.com.

This study explored the impact of two-day training in SFBT for a group of community-based social workers and the changes such brief training makes to a team's practice. Three themes are developed.

1. "Transferring techniques is hard without practice or support." Participants suggested that there were negative perceptions and organisational barriers (in addition to the challenges of simply using new techniques) that would benefit from ongoing supervision and support from

trainers and from the organisation purchasing the training.

2. "Does it fit with my role?" The more innovative and radical tenets of SF Therapy were not always seen to fit with the day-to-day role of the worker in the organisation.
3. "Changing the pattern of interaction." Participants noted very interesting changes in how they were perceived by clients and work colleagues and how they changed, listening more, holding back more and working more collaboratively. These were linked more to general listening skill development rather than particular SFBT techniques.

Participants found that it was difficult to maintain the use of skills and specific techniques without support in the workplace. This was driven by fears that they would not be using new techniques "correctly" and fears about how to cope with client responses to future focused questions in a predominantly problem focused setting. Participants stated they were concerned about using the approach with people with "more entrenched problems". The term "more entrenched" is a concern as it raises the question of whether the fundamental concepts and values of SFBT were understood at the end of the course, particularly the model's refusal to grade one issue as more "entrenched" than another. Perhaps language such as "entrenched", "chronic", "severe" and "lifelong" should not be relevant in this model? I am a little concerned that Smith then suggests that exploring barriers to SFBT "could perhaps form part of a "relapse" prevention section to the course"(p. 340). This concept may oppose the focus of SFBT? De Shazer stated that SFBT was not relapse prevention at his final workshop at BRIEF in 2005. This may be a minor issue but it could raise questions about the participants' understanding of SFBT's world view after the training and may support the need for trainers to make a specific learning outcome that participants will be able to critically analyse or challenge assumptions about chronicity and entrenchment by the end of the workshop.

There were concerns about working with couples and families and here the author provides a useful link. Rhodes (2000) supports SFBT in these situations. Negative attitudes from other staff members and resistance in the team were considered to be barriers to the approach's adoption (which may suggest the importance of training packages that include wider representation from the whole team or some preliminary work on the behalf of trainers to engage with the wider team, e.g. by providing insight sessions or introductory talks). Smith interestingly suggests the lack of "peer organisational support" is a barrier to the model's adoption in organisations and supports this with other study material (Fairhall and Cotton, 2002). Trainees did report changes in their pattern of interaction. Interestingly these changes were not specifically linked to SFBT techniques. The examples from transcripts suggested the change was more about listening skills, "hanging back" and being perceived by their clients as listening and understanding more. The behavioural changes identified by Smith are that the workers used a less directive approach and encouraged clients to collaborate in creating goals and solutions "rather than just offering them off-the-peg answers to problems" (p. 343). There were clear reports of benefits to the working relationship: honesty and transparency, and improved communication. Smith states this is also supported (Sundman, 1997).

Smith helpfully places this study in the context of others on the effects of "extremely brief training" (Fadden, 1997; Kavanagh et al., 1993; Milne et al., 2009). Smith's recommendations include that trainers should ensure that the purpose of the training and intended outcomes are "explicit and agreed between trainers and people at an appropriate level of authority in the organisation" (p. 345). The training should take into account the importance of the trainees' perception of their work roles and priorities. (I would suggest this is often done in SFBT training by including an early exercise asking "what do we need to know by the end of the training so that the skills we learn will be really helpful in our everyday work 'out there in the real world'").

Smith discusses the view that the benefits reported link more to "general therapeutic stance" rather than specific therapy

techniques. He then goes on to suggest that "trainers from many psychological therapy traditions are therefore likely to be in a position to deliver training to enable non-therapists to adopt aspects of psychological therapy practice" (p. 345). Finally, Smith appears to suggest that psychologists, being asked to take on more training and consultation roles, could develop training that mirrors a basic therapeutic model of working "but where the therapy itself is de-emphasised" (p. 346).

Reflections: It is not clear what the content of the two-day workshop delivered by Smith included. However he says that it was "broadly based upon the training methods and structure utilized by the SFBT organization "BRIEF" (see Brief 2010). The content of the training is obviously a key influence on the future evaluation of its usefulness to the team and a factor in how "key techniques" are remembered and how much confidence the participants will have in using them in the workplace. More detail may have been useful here.

There is the sense that the 9 months between the training and the research may have also affected the participants' responses. Finally I am not sure that Smith's suggestion, that it is the generic communication rather than SF elements of training that should be highlighted, is upheld by the data or the discussion presented. The suggestion that trainers (perhaps from other therapeutic orientations) could meet requirements to increase their training role and meet demand for SFBT training by "de-emphasising" SF techniques or the "therapy" element of the approach is worrying and may throw the baby out with the bath water. The research presented may equally be used to argue that those leading workshops in SFBT need to have a high level of specialist SF skill to embed the techniques and ensure relevance for the participants. The findings could point to more specialisation and SFBT focus, not less.

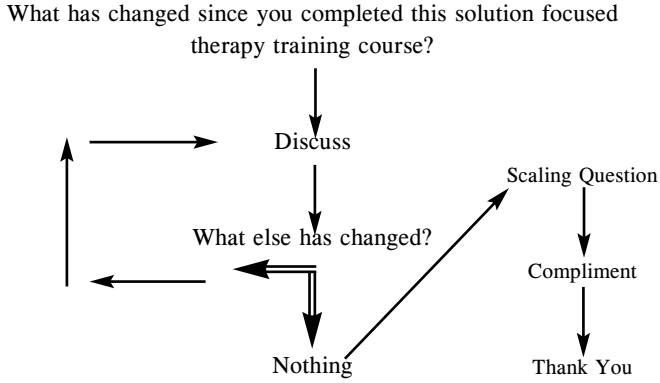
Where Smith is at his most effective is in making the case that practitioners on the "front line" may need packages of ongoing support and supervision to maximise the effectiveness of brief introductory workshops and the cost effectiveness and utility to the organisations that fund them.

Smith, S. (2010)

A preliminary analysis of narratives on the impact of training in solution-focused therapy expressed by students having completed a 6 month training course.

Journal of Psychiatric and Mental Health Nursing 2010, 17, 105–110. Blackwell publishing.

This pilot study (also by a Smith! What are the chances?) explored the self-perceived impact of six months SFBT training on nurses. A constructivist approach was used, linked to the EBTA research definition for an SF interview (Beyerbach, 2000). Therefore the research process adopted a theoretical stance mirroring the SFBT practices to be investigated. The interview schema followed an SFBT structure.



The scaling question on whether participants gained what they expected from the course had a mean score of 9.8 (range = 8-12) (p. 107).

Interviews were audio taped and a focus on narrative accounts and narrative research was adopted based on Polkingthorne (1995).

Three themes emerged:

1) There was more trust in clients, and trainees were working in a more collaborative manner with genuine respect for strengths and abilities. There was positivity and enthusiasm expressed by the participants for working with the clients. The fact that Interviews were carried out 8 months after the taught component of the training spoke to the success and enthusiasm for SFBT. Participants were keen to have more difficult cases.
2) Confidence. Participants specifically stated that one- or two-day trainings "generated an interest to know more about the approach but participants had been reluctant to utilise an approach in clinical practice without a deeper knowledge of its theoretical underpinnings" (p. 108). Smith discusses a shift of allegiance from the team to allegiance to the client and there were positive statements suggesting that the model allowed mental health nurses to do what they came into the job to do. This also suggests that this group felt their job roles did not conflict with and were not a barrier to SFBT in contrast to the first research study discussion above. The author advocates Tomm's (1987) concept of research as interventive interviewing, as with clinical applications of the model the research interview is seen as a therapeutic opportunity, and mirrors the SFBT model. He concludes that 6 months' training has a significant impact on students. The depth of theoretical and philosophical understanding as well as practical knowledge correlated with confidence and ownership of SFBT practice. I particularly liked the fact that the model used to research mirrored the SFBT model explored.

Reflections: So, long or short training for SFBT, which should it be? Interestingly, the length of the 6-month training may not account by itself for the change in enthusiasm and confidence of the participants reported by Smith (S not Ian).

One factor identified was the opportunity for students to learn the underpinnings and philosophy of the approach as well as techniques. This could be included in shorter trainings. If we train from the values, beliefs and philosophy of SFBT, it may be possible to engender more confidence and trust in the techniques and in the clients' abilities to change even when the training is short term. The participants in the second study did not highlight technique or technical ability as relevant 8 months later and the participants in the first study also did not talk about particular questions or set piece interventions. This may indeed uphold the initial ideas of Ian C Smith that it is general changes in interviewing style rather than SFBT content that is important to participants in training. However the sense of identity as being SF that the second study participants showed and the clear indications that this was a change and improvement on other approaches and models they had used seems to challenge a conclusion that it is not the SFBT element that is important in SFBT training and that generic trainers can train SFBT effectively. Which comes first, the technique or the values and attitudes? Like learning a martial art or an instrument the answer is probably both. "Feel" and technique are co-joined.

From these two studies it seems that when training in SFBT we need clear collaborative goals and outcomes for each training session. Very important is what the organisation wants to get from our involvement and how it will support staff to adopt the model. How are trainees going to keep going in the real and stressful world of work once this training is over (even in the face of negative comments) would be worth including. I would suggest that trainers could think about including or costing supervision packages and support into proposals for commissioning agencies, or perhaps structure three-day events (two days, a gap and one day follow up or "supervision" sessions over time) to help teams keep going.

It seems from both studies that "more is not necessarily better – better is better". By getting better at delivering training that fits, has a supervision element, is practical and

that ensures the beliefs and values of SFBT are understood (as well as the techniques), both these research papers suggest we may have more impact and create more confident and innovate practitioners of the model.

Cepukiene, V and Pakrosnis, R. (2011)

The Outcome Of Solution-Focused Brief Therapy Among Foster Care Adolescents: The Changes Of Behaviour And Perceived Somatic and Cognitive Difficulties.

Children and Youth Services Review 33, 791–797.

A quantitative study using a manual-based application of "standard" SFBT techniques was undertaken. The authors evaluate SFBT as an individual intervention among foster care adolescents. The research was conducted in seven foster care homes in Lithuania. The authors used both "treatment" and control groups, and the average age was 14.6 years. Groups each consisted of 46 adolescents.

Participants in the "treatment group" attended a maximum of 5 sessions of SFBT-based individual work. The authors cited research that indicated significant changes occur during the first three sessions of SFBT as a factor in deciding on five sessions (Draper et al., 2000, Schaefer et al., 2003, De Jong & Berg, 2002). An SFBT manual was composed to constitute the formularised delivery of SF techniques in the sessions based on Beyerbach (2000) and De Jong & Berg (1998). In the manual, the procedure of therapy including specific techniques, their sequence and variations depending on client's responses were described. Compliance was reviewed after therapy completion. Sessions met the protocols if they included exception, miracle and scaling questions and detailed exploration of these topic areas, and if an intervention message had components of compliments and tasks. Subsequent sessions were measured against the use of

what's better, scaling questions and interventions including compliments and task. Post-treatment evaluation for those in control and treatment groups used a standard scale "interview for the evaluation of adolescent's problems" at six weeks.

The treatment group reported a decrease in difficulties in both assessed areas (behavioural change and cognitive or somatic processes) and this change reached statistical significance in the area of behavioural change. Positive changes in the treatment group were larger in both assessed areas. Participation in SFBT was beneficial for foster care adolescents in improving their behaviour and this is in line with findings from Corcoran (2006), Gostautas et al. (2005) and Gingerich & Eisengart (2000). The authors note that somatic and cognitive difficulties saw less remarkable changes than in the behavioural category and suggest that the model's focus on small describable differences may explain this. They also consider that perhaps longer between treatment and follow-up phases is needed for change triggered by these small behavioural shifts and successes to register and alter systemic cognitive or somatic processes. The authors puzzle with the issue of "what percentage of participants achieving reliable and clinically significant change should be reached in order to say that the intervention is an effective one?" (p. 795). This strikes me as the puzzle that accompanies those attempting statistical, empirical quantitative research methodology when exploring the post-modern, co-constructivist nature of SFBT. De Shazer's maxim "never do anything always" confounds a manual-based standardised delivery. When does reported change become change that is enough for us to prove the model helps? When does the demand for rigorous research tools limit the model's creativity and humanity? This is a tough issue, but to their credit the authors here carefully explore it and also explore limitations to the study honestly and transparently. An interesting, rigorous and well-written piece of research that adds to the growing "statistical" body of evidence that SFBT is effective.

Fearrington, J.Y., McCallum, R.S. and Skinner, C.H. (2011)

Increasing Math Assignment Completion Using Solution Focused Brief Counselling.

Education and Treatment Of Children 34(1), 61–80.

This paper seeks to explore the effects of "SF Brief Counselling" taken by the authors from de Shazer and Molnar's paper of 1984.

Curiously the authors' definition of this approach states the goal as "being to solve presenting problems by identifying and altering specific student behaviours in the natural environment". The approach developed from the 1984 paper is supported by reference to Downing and Harrison (1992), Lafountain et al. (1995) and Mostert & Mostert (1997). Shapiro (2004) is also cited as developing a motivational strategy to "remediate performance deficits" (p. 62). Thompson and Rudolph (2000) is used to define "basic steps to SF therapy". "Initially the therapist clarifies the problem and assesses the client's motivation to change. The client is then asked to identify unsuccessful attempts to solve the problem." Since this activity is problem-focused and bears little resemblance to SF practices in education, counselling, supervision or organisations and since no de Shazer text later than 1984 is referred to in the literature review section, this paper is puzzling and raises questions about the definition of SF used throughout the piece.

This case study took six African American students (three boys and three girls) enrolled in the fifth grade of an inner city elementary school (10 or 11 years old). They were recruited by asking their teachers whom they would like to be involved in the study. Attendance, skills deficits and a review of records showed that students nominated had returned less than 60% of their maths assignments.

SFBC treatments were delivered over five weeks, one a week per student. The "treatment" included students being

asked to rate the severity of the problem on a 1-10 scale and describe what needed to happen. The miracle question was then asked and techniques such as cheer leading, positive blame and "flagging the minefield" (identifying obstacles in the way) applied to the sessions. A written message containing three compliments, a bridging statement and a task were given. It was not clear if this was individualised for each participant.

The results showed large increases in the percentage of assignment completion for each student ranging from 34 – 69%. The authors suggest that SFBC should be explored more as a method in educational settings. There are many variables potentially affecting the students during the study, for example what effect would any additional support from an educational psychologist have had on this group and to what extent was it SF that had an impact? The curious description of problem-focused starting points and scaling obstacles for change, as well as issues about recruitment methods, suggests a level of caution and curiosity must accompany the findings.

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