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Welcome to this first issue of Solution Focused Research Review. My name is James McAteer and I am pleased to have been invited to 'guest edit' this edition.

The core theme of this edition is that all the articles are research based. That is, they follow a line of investigation and examine the extent of the usefulness of their respective solution focused brief therapy practice.

A professional knowledge base developed through research is an important aspect of work place activity. Practices that are shared widely across the profession should be limited to those that are most likely to produce better results. Those procedures that get better results across a number of practitioners and among your clients are the ones that are worth sharing and only these belong in the shared professional-knowledge base of solution focused brief therapy. The articles featured in this edition do exactly that.

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Introduction

As well as completing the MA in Solution-focused Therapy in Birmingham, Carolyn Emanuel is a counsellor in the British National Health Service. She has been a governor in a primary school and is also a parent. She therefore brings a wide knowledge of her subject to this dissertation and the associated research project.

The study addresses anger management in primary school children using a solution-focused group structure. Similar projects have been run elsewhere and have demonstrated some benefits. Key themes were found to be Achievement, Behaviour, and Relationships with others. Scaling techniques were used to rate the children's self perceptions. At the final session this was done using an action 'walking' scale. The useful concept of 'a dream day' was employed as a variant of the miracle question and seems a good formulation for children of this relatively young age.

The results from children, parents and teachers support the use of this method in this age group. Follow-up at six months showed that the changes were maintained. It will be useful to repeat this study with larger numbers of children or perhaps within a different country's school system, to see if the benefits of the method can be generalised to all primary schools.

Dr Alasdair J Macdonald

Carolyn Emanuel completed this research paper as part of her study in 2004 for an (MA) Masters of Arts in Solution Focussed Therapy Carolyn spent over six months evaluating the use of Solution Focused intervention in an Anger Management Group for school children, aged seven and eight.

Whilst studying at Birmingham University on the MA in Solution Focused Therapy course I was, among other things, working in the UK National Health Service and a governor at my children's primary school. Myself and other members of the school staff started talking about the Solution Focused Approach and before long, five of them;including the Head Teacher, had attended a four day SF course and arranged a training day with the entire staff. It was from this basis that I started working with the Learning Mentor running SF Anger Management Groups (SFAMG) at the school.

This study had a sample size of five, (A,B,C,D and E) forming the Group of seven/eight year-old children involved in a SFAM Group that operated from May 2002 to October 2002.

The research was evaluating the process and benefit of SF intervention in an anger management Group for seven/eight year olds.

The aims of the research were

1 To describe and critically analyse the process of the intervention

2 To identify the differences made by the Group intervention to the children over time.

3 To provide an analysis of the process of SFAM Group work in primary schools.

By running the Group and collecting and analysing data the following questions were posed:

1 Is a SFAM Group a useful experience for seven/eight-year old children?

2 If it is useful, are the benefits maintained after six months?

This study is about children experiencing the Group and the researchers exploring the

differences this experience made on different areas of their lives.

The main purpose of this research was to understand the process of the intervention from the perspective of the participants, their carers and school staff. The role of the researcher was to initiate and facilitate change, collect and disseminate information. Qualitative research methodology was chosen due to its ability to critically analyse processes of an intervention. It looked at levels of satisfaction and the goals reached.

The aims of the Group were

1 To provide a useful opportunity for children displaying behaviour unacceptable to the school and to explore alternatives in a safe setting.

2 To encourage children to become aware of the effects of their actions, thoughts and behaviour upon themselves and their environment.

3 To help children develop their skills and opportunities and to resolve their own differences, promoting self-reliance.

Staff selected children to the Group based on levels of underachievement, disruptive behaviour and angry outbursts in school. The children in the Group were seven years old at the beginning of the Group. Six children were selected to form the Group. Four boys and a girl completed the Group. One child left the school and was not included in the final study. There were two facilitators. The Group ran for ten sessions.

SF rating scales were used on four occasions throughout the Group. The primary purpose of scales in counselling sessions is as a therapeutic tool to formulate goals, measure progress and make priorities for action (O'Connell, 1998). In this study, a scale was used to formulate Group member's goals in the initial interview and then to measure progress at different stages throughout the Group.

At the initial interview the following scale was used.

0---1---2---3---4---5---6---7---8---9---10

0 being the worst it had ever been.

10 totally under control

The following questions were asked of each person:

1 Where are you on the scale today?

2 Where would you like to be on the scale?

3 What would be happening if you were one step on from where you are now?

Due to the age Group, the questions were asked in ways the children could understand and work with. Sometimes this involved extra time and creative thinking from both the child and facilitator.

Different scales were asked at throughout the Group sessions:

0 = worst anger has been and 10 = things more under control. (session 3 and 5)

0 = everything is awful and10 = everyday is the day I dream about, (session 10)

0 = everything is a problem and 10 = all my problems are solved (session 10)

0 =I am never in control of my negative feelings and 10 = I am always in control. (session 10)

A qualitative approach was chosen as the study was concerned with understanding the behaviour from the children's own frames of reference. Different approaches to qualitative analysis have been used to organise the data and formulate conclusions which involved consolidating the data. The aim of the analysis is to offer a readable,

understandable and practical account of the effectiveness of the treatment offered.

The themes identified from the descriptive information collected from the interviews were: Achievement, Behaviour, and Relationships with others.

Information was collected using interviews with the children, parents/carers, teachers and playground staff. Information was also collected using rating scales, from the lunchtime behaviour book and observations. Permission was given for the children to participate in the study and to be recorded on audio tape. Permission was also given so that interviewees could be contacted by the researcher before the Group began.

Semi-structured interviews were carried out with teaching and playground staff, parent/carers and Group members before the Group formed, after the Group finished and at six months follow-up. Teachers and playground staff were asked about the children they were in contact with and parents/carers were asked about their own children.

Information was also collected from the school's behaviour book. This is a record of incidents of 'problematic' behaviour in the playground recorded by playground staff. In this study it was useful to have the books to compare incidents of 'problematic' behaviour before and after the Group occurred.

The facilitators were continually observing the children throughout the sessions and recording notes. Observation provides additional 'real life' information about the intervention and strategies that appeared most successful

Process notes were written after each Group which included observations from the facilitator, who was also the researcher. Activities were aiming to concentrate on what worked for the children in terms of their behaviour. It was aimed to balance the programme between what the children enjoyed doing and what worked for them to help change behaviour in ways they decided would be best for them.

Parents, staff and children were interviewed before the Group began, within two weeks of the Group finishing and six months later. At each interview information was collected about the children's own perceptions and perceptions and observations of others. The following numbers were interviewed:

1 Parents/carers of each Group member (60%, 80%, and 100% respectively).

2 Teachers (100%).

3 Playground staff involved with those pupils at the school (100%).

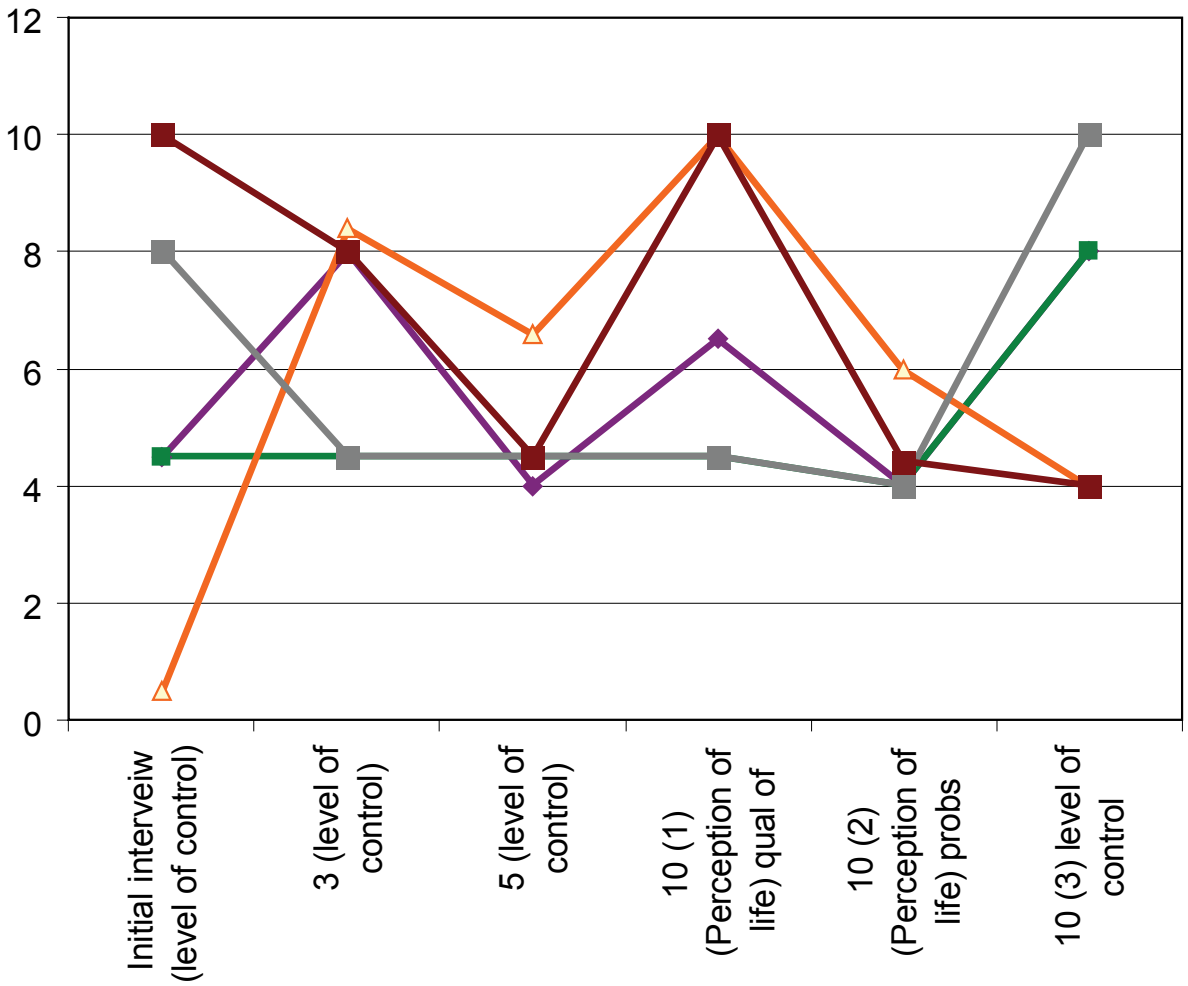
4 Children who took part in the Group (100%, 100%, and 80% respectively).

Results

The teachers stressed the importance of academic achievement. It is understandable that they will comment more on achievement issues as it fits in with their role, training and interests. They considered behavioural problems to be linked to low achievement and achievement with acceptable behaviour.

Teachers noticed a higher degree of achievement or identified particular difficulties in achievement after the Group.

The different aspects and experiences of those interviewed produced a wide variety of information about the children's behaviour. The playground staff noticed behaviours that threaten their authority and consider behaviour management to be their main concern. This fits with their role as monitors of behaviour in the playground. This also explains why they commented more on behaviour than other themes.



All the children initially presented with problematic behaviour associated with temper outbursts. Child B 'winds people up when they call him fat' and loses his temper easily. Children A and E were particularly identified as having bad tempers with children and staff.

The playground staff associated temper outbursts with aspects of bullying. Child D was regularly 'bullied' in the playground, which he tried to deal with in different ways. Although little detail about how he dealt with this was given, it was noted that he often became angry.

Graph 1: Results from the rating scales by each child throughout the Group

The graph shows (graph 1) how the children rated themselves on the scales:

a. 0 = anger the worst it had ever been and 10 = anger totally being under control (initial interview)

b. 0 = worst anger has been and 10 = things more under control. (session 3 and 5)

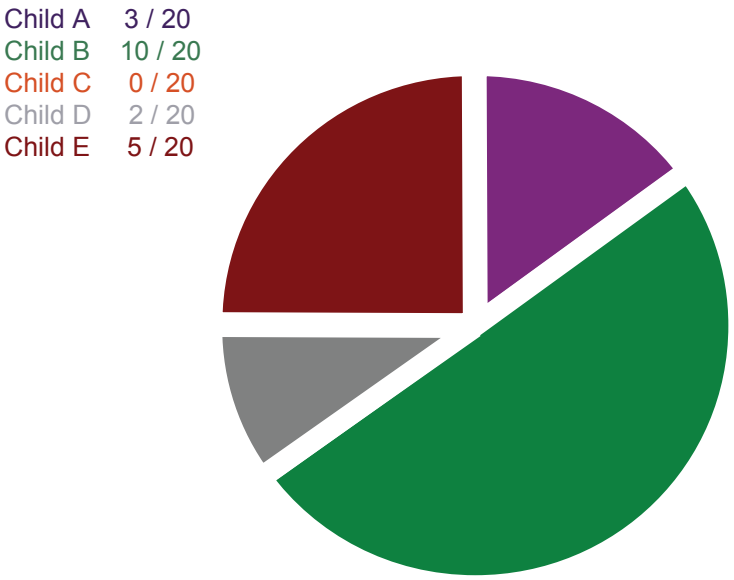
c. 0 = everything is awful and 10 = everyday is the day I dream about, (session 10)

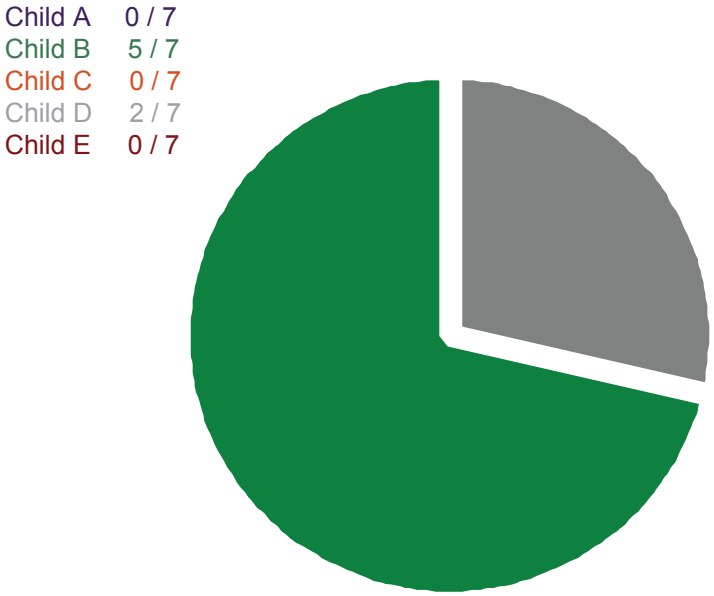
d. 0 = everything is a problem and 10 = all my problems are solved (session 10)

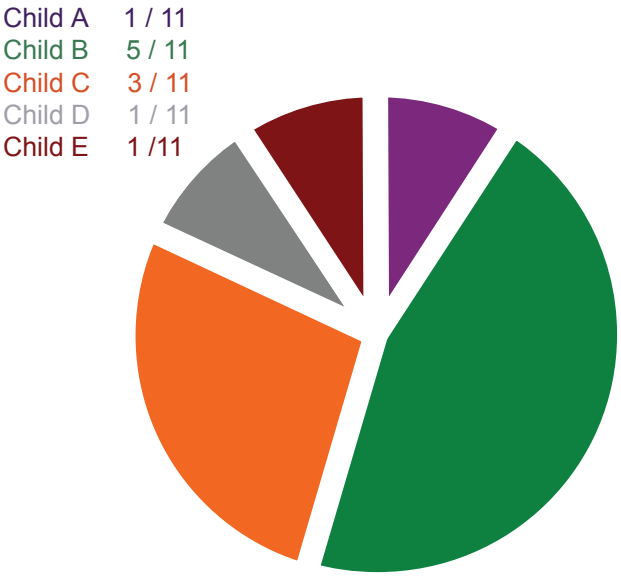
e. 0 =I am never in control of my negative feelings and 10 = I am always in control. (session 10)

At the end of the Group all children except one (E) were higher on the scales on average than at initial interview or partway through the Group. This implies that they were feeling more in control of their anger and generally had a more positive perception of how things were.

The three different scales at session 10 were asked using the physical action method (stepping on the stepping stone and physically moving). No children positioned themselves lower than four on any of the three scales. The children were midway or higher (up to ten) when asked how near to a dream their days were. When asked how they perceived their problems all the children were between four and six. One child considered his problems more solved than unsolved. Three of the children (A, B and D) felt fairly in control of their negative feelings most of the time.The average score calculated for the three scales from session ten were between 6.3 and 6.6.







Both parents/carers and the children themselves perceived themselves as being less angry after the Group than before. In the interviews with the children they said

'the Group has helped me not get into trouble'
'I go and tell the teacher rather than fight'
'things are different and I don't want it to be like it used to be'.

Graph 2 Results from lunchtime behaviour book

Results from the behaviour book (graph 2) showed that fewer incidents were being recorded over this period for all children except child C who was described as very quiet in the playground when the Group began. On average the same type of behaviours were recorded.

Overall results indicate improvements in behaviour associated with anger recorded by the children and other adult informants. They also continue to show evidence of angry behaviour at times.

The school, which was chosen because of its convenience, was highly suitable because of its beliefs and ethos. The Head Teacher was already keen on the SF model and the staff had received different levels of SF training. The teachers and staff involved in this study had previous experience of looking for improvements in the children they taught and were keen for the results of the research to be positive.

All the children, including those who felt there were gains from making changes and those that didn't, were keen to attend the Group. All the children had been referred by their teachers and given permission by their parents.

This research engaged the children in terms of attendance and compliance with the Group process. It was necessary to understand each child's unique worldview and its benefits. The aim was to work collaboratively in order to discover exceptions and identify new possibilities and choices. The children's choices were limited to within their subculture as were the facilitators to their own subcultures.

The facilitators were both women. This seems significant especially because the Group was formed of a majority of boys. The facilitators were from different cultural backgrounds. Having a facilitator from a black and ethnic minority Group was important, as the Group comprised of children from these Groups.

In terms of the data collection, a high percentage of possible interviews took place providing a wide range of opinion of effects of this Group. Rating scales and results from documents were a reliable source of data.

Natural developmental factors were considered with this age Group. It was noticed that when using rating scales the children found it difficult to distinguish between 'where they are now' and 'where they want to be'.

The average scores from the three rating scales in session ten show that three fifths of the children were less angry at session ten compared with before the Group. This indicates improved self-evaluation by more than half of the children. The children who were angrier at session ten were those that rated themselves high to start with (in control of their anger) and scored themselves at six out of ten at the end of the Group.

Significant findings of this study in the light of some existing published research

This study found that the children described themselves more favourably and therefore seemingly had higher self-esteem after the Group. This is a similar finding to the study by LaFountain et al (1996a, b, c) where she found that children assessed themselves high in self-perception scores regarding their feelings and attitudes.

The results of the present study suggest that the children perceived themselves as less angry after the Group than before. These results are consistent with those of Schorr (1997) who ran a SF/CBT anger management Group with adults.

This study with the children showed some maintenance of improved behaviour at school and at home over a six-month period. In Hemphill's study (2001) she found improved behaviour at home but not at school, and that improvements were maintained, and sometimes improved, over a one-year period.

Limitations of the study

This is a small study that had limitations in its design, the reality of the situation and its evaluation. It is difficult to come to significant conclusions with a sample of this size and with no control Group to compare with.

The researcher was also the Group facilitator, which questions issues of objectivity, reliability and validity. The nine-week break during the summer holidays affected the results of this study. The Group was planned as a SF Group and all written plans were according to this. Nevertheless, there were no opportunities to check the extent of keeping to the SF model in the sessions. There were no videotapes or transcripts that would have increased the validity and reliability of the results and further control of researcher bias.

Conclusions

This study has shown that a ten session SFAMG with seven/eight year-old children has made some differences to self-perception and behaviour. Some of the changes identified by the children and observed by significant adults in their lives have been maintained at six months. There is evidence that angry outbursts continue to occur although these are noted to be less severe and less frequent. Whereas all the children were said to have temper tantrums before the Group began, only some of the children experienced these after the Group and at six-month follow-up.

Achievement, behaviour and relationships with others were identified as recurring and significant themes throughout the interviews. Teachers noticed a higher degree of achievement or identified particular difficulties in achievement after the Group. Improved behaviour and better responses to discipline were noted as significant by the children and others. Some children formed significant friendships, positively affecting many areas of their lives

Results from scales showed changed views of anger over the eighteen month period. By the end of the Group no child scored themselves as severely angry and some scored as having no angry feelings whatsoever. There were fewer incidents recorded in the behaviour book at the end of the study. The number decreased to a third of the original total, directly after the Group. This was largely, but not totally maintained over six months. Whereas the rating scales, being a self assessment is comparable only to past and present self assessments, the records from the behaviour book is a more objective assessment. Both recorded improved behaviour which supports a valid and reliable piece of research.

Results of this study support some published research and refute others. Some studies are partly supported by the results of this study.

This study has shown that the SFAMG has been partially useful for the seven/eight year-old children. The children were provided with the

opportunity to talk about their anger whilst focusing on what they were already doing to make changes to unwanted behaviour and their unique pictures of how they would prefer things to look like. This has proved to be a useful approach and both self reports and reports from others have identified changed behaviours.

The changes have been partially maintained over time. The children and adults identified that those experiencing the Group were less angry than before the Group began.

This study continues to question exactly what made the difference. However, qualitative reports show that the Group process had some impact and has influenced the children enough to support more Groups like this to take place in primary schools and for more research to be undertaken. These children have made significant changes in the face of a significant level of adversity.

It is now five years since this study took place and these children, as far as I know, are all settled into secondary schools. Many children of this age are struggling and it is in my opinion that more work to help young people find their own ways to move forward is vital. I know that exciting work is taking place to help young people using the SF approach. I believe passionately that this is an effective model to use and more research needs to be done to help it become more widely known and accepted.

References

- Hemphill, S. A. and Littlefield, L. 2001) Evaluation of a short-term Group therapy program for children with behaviour problems and their parents. Behaviour Research and Therapy 39 pp. 823 – 841.
- LaFountain, R. M., Garner, N.E. and Eliason, G. T. (1996a) Solution Focused Counselling Groups; A key for school counsellors. The School Counsellor 43 pp. 256-267.
- LaFountain, R., and Garner, N. (1996b) Solution focused counselling Groups: the results are in. Journal of specialists in Groupwork 21 pp. 128-143.
- LaFountain, R, and Garner, N. (1996c) Solution Focused Counselling Groups. The School Counsellor 43 pp. 256-267.
- O'Connell, B. (1998) Solution-Focused Therapy London, Sage
- Schorr, M. (1997) Finding Solutions in a roomful of angry people. Journal of Systemic Therapies 16 (3) 201-210.
- Stringer, B., and Mall, M. (1999) A Solution Focused Approach to Anger Management with children. A Group Work Manual for Practitioners. The Questions Publishing Company, Birmingham, UK.

Carolyn Emanuel

Guy Shennan describes a study which provides evidence for the usefulness of solution focused practice beyond the therapy room.

Introduction

This study examines the use of solution-focused approaches within a small family support team in UK Social Services. The method involved training, feedback forms from workers after three months in practice and a detailed post-session interview for one case with each worker.

The findings support other research in highlighting the use of scales as a major tool, and the value of coping questions. Goal setting was not always explicit, with agency policy being privileged over the goals of the users. Workers found the techniques easy to use and applied them often in their work. This is important in the UK context, where workers are expected to achieve major change in families who have many problems and who do not always welcome their contact with statutory services. The miracle question was rarely used directly, but workers devised useful alternatives of their own to uncover and develop a future focus. It may be that in the future process research should attend more to contextual issues, rather than assuming that the elements of therapy can be examined without regard to the agency and the needs of the attenders.

Dr Alasdair J Macdonald

Guy first came across the solution focused approach while working in an Adolescent Psychiatric Unit in the mid 1980's. Working as a social worker in the 1990's he pioneered the use of the approach in statutory settings. Having developed an early intervention therapeutic service for families in the voluntary sector he set up his own solution focused consultancy in the East Midlands. Guy was part of the first intake on the Birmingham MA in 2000 and has been working at BRIEF since 2004.

The study set out to discover the effects of this exposure in terms of actual day-to-day

use of the approach. The findings would put the claim of applicability outside of therapy to the test. The views of the team members were to be sought regarding the following:

• To what extent and in what ways is a solution focused approach used by a Family Support Team?

• How useful is a solution-focused approach to the work of a Family Support Team?

• In what ways is a solution-focused approach useful to the work of a Family Support Team?

• What aspects of a solution-focused approach are useful in particular?

Methodology

In order to answer these questions a flexible research design (Robson, 2002) was developed and data was collected during a three-month research period in the following ways. Each worker was interviewed at the end of the three months about their use of the approach during this period. To help the workers to recall and reflect on their practice during these 'final interviews', they were asked to complete a form immediately after each of their visits or sessions with a family or family member during the three months. This 'post-visit form' asked the worker to rate how solution-focused the visit had been on a five-point-scale from 'not at all' to 'completely'; what aspects of solution-focused practice had been used; and how using it had been helpful. Although it had not originally been intended that the information from these forms would be used as part of the research data, it did prove to be useful in supporting the study's findings. During the three-month research period each worker was also interviewed about one family visit in particular, in each case less than 24 hours after the visit. These 'post-visit interviews' maximised the chance of obtaining rich descriptions most closely resembling the practice as it actually happened, thereby adding to the specificity of the data.

Findings

Overall use of the approach

In the final interview the FST workers were asked to judge how much they had used the approach in the preceding three months on a five-point scale, where 1 meant 'not at all' and 5 'all the time' or their most used method. Their answers are set out in Table 1.

Table 1 – Amount of use of solution-focused approach according to final interviews

Worker	A	B	C	D	E	F
Amount Used	4	5	2-3	3-4	4	1-2

Table 2 – Use of solution-focused approach according to post-visit forms

Worker	Number of post visit forms	% of visits where SF used	Amount used - mean	Amount used - mode	No. of 'overall SF' sessions
A	12	100%	4.2	4	3 (27%)
B	15	100%	4.5	5	11 (73%)
C	15	73%	1.9	2	0 (0%)
D	38	82%	2.9	4	0 (0%)
E	19	95%	3.2	4	0 (0%)
F	37	37%	1.4	1	0 (0%)
Overall	136	76%	2.8		14 (10%)
Overall less F	99	88%	3.2		14 (14%)

Several features of these figures are worth commenting on. First, there is a reasonable level of correlation between the two sources of data, which is useful triangulation for the findings regarding how much SFA is used by the FST. Second, the figures show that the SFA is frequently used by most team members, all apart from one of whom used at least some of it in all or the great majority of their visits. Third, there are clear differences in how much the approach is used between the team members. Only two (A and B) saw any of their visits as being solution-focused overall and one worker, F, seldom used the approach. C gave the second lowest rating on this scale, although she spoke enthusiastically during the interviews about the approach, which she found 'inspiring'. Her estimation of the amount she used SFA actually increased as she talked about it:

"…if I was actually to think about how much I use, how much I encourage young people or families to think about how they want things to be different, and what's happening already that they see as good and positive, I think that I do that quite a lot, and, I think that I use it more than I put down on paper…"

This may be an example of social constructionism at work – the more the worker talks about her use of the approach, the more she uses it – and this idea should influence how we treat subjective data. The fact that C and F were the two newest team members and had received the least training in SFBT is also a relevant factor.

Use of aspects of the approach

Enquiring about use of the various aspects of solution focused practice yielded some interesting findings. It was clear that exceptions and achievement were focused on more than the future. Hogg and Wheeler (2004) noted that the statutory social workers in their study did not refer to goal-setting, and wonder whether "this was such a routine that it no longer stood out as a tool" (p308). The responses of the FST workers suggest that something a little more problematic may be going on. In solution focused therapy it should be relatively straightforward to focus only on the client's agenda, as the therapist, in theory at least, has no agenda of his or her own. The FST, however, has the very clear agenda of preventing young people entering local authority accommodation. So, although some workers did describe how they found out what families wanted from FST's involvement, F's comment may have resonated with others:

"I don't ask 'goal-setting' questions. Normally this doesn't seem relevant as the work is governed by the agency goal of keeping young person out of accommodation."

Whether or not the overall goals of the work were set by the clients or the agency, most team members did ask clients about preferred futures. Those who did so most often described the usefulness of these questions, for example by helping a teenage boy worried about a contact visit with his mother to "cue himself up for it to go well", and by helping to maintain the involvement of a girl who had had enough of difficulties being aired. Nevertheless, in comparison to other aspects of the approach a future focus appeared to be utilised only sporadically by the FST workers.

Scaling proved to be the most popular and most frequently used technique in the team. One worker used scales at the beginning of first sessions to help with the description of preferred futures and at the beginning of follow-up visits to elicit progress. They were found to be useful in measuring progress, in particular towards the aim of keeping a young person out of care. Another worker described using a variety of scales with a boy and his father to talk about their progress individually and about the relationship between them. A common response was that clients liked scaling questions and that they helped young people in particular to talk, one worker being 'astounded' at the list of achievements that a scale helped to produce.

Almost all the workers used coping questions and appreciated their value, by being relatively straightforward to use "it's a very easy one to get

into", and because of their 'powerful impact' on a client's self-perception.

The majority of workers had never or only rarely taken a break, but a couple of exceptions are worth highlighting. While the team's most solution-focused worker had had difficulties with the technique:

"I'm certainly taking more breaks…I couldn't say I do it every single time, and that really is a big move for me, and pretty much always I find the break very useful and even when I'd thought to myself "oh God, you know, can I take a break?" when I have taken it, it's made sense to me to have taken it after the event."

What he found useful was how the break punctuated the session, and enabled time for the careful formulation of evidence-based feedback. The other example shows how practice developments can happen accidentally. The most experienced FST social worker was visiting a woman who was complaining vociferously about the behaviour of her 14-year-old daughter, saying that she might have to go into care. Fortuitously, she then had to go to see to her younger child in another room:

"…and I thought, well I'll just do this taking a break business…I've never done that before".

Having the chance to think and to read through her notes, the worker noted that there had been a number of positive aspects to the visit, particularly in some of the ways the mother was coping and trying different approaches with her daughter.

"It was useful to draw a line under the rest of it and then just feedback in positives, and end on a good note, not leave when she was talking about this care business. That was probably the most useful bit that happened today".

Usefulness

As well as being used by a majority of the workers in a large part of their work, it was also clear that the approach is proving to be useful to them, in several ways, including:

- the clear structure it offers
- in helping to engage and maintaining the involvement of young people
- offering questions which clients can answer and which can obtain useful information
- helping to 'get alongside' clients in crisis and at the same time 'lifting' them
- its flexibility and 'portability'
- in identifying and measuring progress, via scaling in particular

Added to these factors, the workers using the approach believed that it was instrumental in helping the families they were working with to make positive changes in their lives.

Discussion and conclusions

It is clear that a solution-focused approach is used to a significant extent in the Family Support Team. There are variations in the extent of its use and a couple of observations are of interest in connection with this. First, the most obvious difference is between the two workers who had received the least training in the SFA and the other four workers. While the numbers are small and these are certainly not statistically significant findings, this does support the notion that the SFA is a 'trainable' model and that training is likely to lead to its use.

Second, experience is a factor to take into consideration when introducing the SFA as a new model into a team. Although new to the FST, F was an experienced social worker, who found that solution-focused ideas did not "come naturally", especially given his "traditional, comfortable and

established way of working". Added to this, the research itself had caused him some difficulty: "(It) felt as though it's something that was being made virtually compulsory…and it's like, well, what if I don't actually feel very comfortable about doing this?"

On the other hand, the two other most experienced workers both frequently used the approach. An implication of this is that the SFA could have much to offer workers, however experienced, but that care should be taken to introduce it in non-impositional ways.

Some of the most interesting findings were about the differential use of the various solution-focused techniques. Goal-setting is used by some but questions about its necessity or relevance in this team's work are raised in the light of its clear-cut agenda. The miracle question is shunned by most, and although some had found alternative ways of eliciting preferred futures, future-focused questions were among the more weakly used. This should give pause for thought for future training and practice development, given that a future focus is central to the SFA (O'Connell, 2005), with alternative future-focused questions perhaps substituting for the miracle question. Scaling, on the other hand, is greatly valued and found to be extremely useful, and its use could be further developed and emphasised on training courses. In contrast, taking a break was seldom used and all workers expressed a difficulty with this. However, those who had done so found taking a break to be one of the most useful aspects of the SFA. It would therefore be sensible to consider how greater use of breaks could be encouraged.

With regard to future research implications, this study would be straightforward to replicate in other teams, whose specific circumstances would produce their own specific results. Another possibility would be to focus on the use of specific techniques, this study suggesting that a magnifying glass could usefully be applied to goal-setting, future-focused questions and taking breaks in particular. Focusing on specific uses of the solution focused approach and its techniques could help us to move towards a preferred future of its optimal usefulness to family support social work and other activities which take place beyond the therapy room.

References

Hogg, V. and Wheeler, J. (2004). Miracles R Them: solution-focused practice in a social services duty team. Practice, 16, 299-314.

O'Connell, B. (2005). Solution-Focused Therapy (2nd edition). London. Sage.

Robson, C. (2002). Real World Research (2nd edition). Oxford: Blackwell.

This article summerises a research study undertaken for the MA in SFBT at the university of Birmingham

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Paul Hanton presents his Masters paper on measuring Solution Focused Brief Therapy in use with clients with moderate to severe depression using a 'bricolage' research methodology

Paul Hanton has been a Solution Focused Practitioner since 1993 and gained an MA in SFBT in 2005 after being on the first course in Birmingham in 2000. Paul Has worked in drug and alcohol agencies with young people and adults, and left full time paid employment in 2004 to set up his own business providing therapy, supervision, training and consultancy. Paul currently works 10 days per month including a day per week in an NHS psychology department, working with depression, anxiety, OCD and other issues. Paul's main interest in SF is the 'discovery' of strengths skills and resources and the exploration of 'what works' for people.

Introduction

Paul Hanton is a very experienced practitioner who undertook the Birmingham MA course. This research project was undertaken as a part of the requirement for the degree. After reviewing the relevant literature briefly, it examines the 'bricolage' approach to action research. This approach depends on the use of existing materials and tools, rather than developing tools or methods for a specific project. In his small sample, the author reports the use of an objective measure of depression before and after treatment, with data available for seven attenders. He also reports the findings of post-therapy interviews with these individuals. They were able to say which elements of solution-focused technique they found helpful and to identify which elements were less helpful.

This study adds to our knowledge of the solution-focused process in a real-life setting. In view of the long experience of the therapist, it may be assumed that the techniques of therapy were applied consistently, so the findings have some validity. The results of treatment were good even though some techniques were not helpful. Some of the findings challenge previous research. For example, end-of-session feedback was not found helpful, even though it has been a part of the model since the outset. Clearly further work on refining the therapy process is needed.

Dr Alasdair J Macdonald

Abstract

The paper reported in this summary fulfilled the requirements of Birmingham University in awarding a Masters of Arts degree in Solution Focused Brief Therapy.

The research was carried out in 2002/03 and the paper submitted in 2005, the Masters was awarded in 2005. The original paper is available on request to:

paulhanton@blueyonder.co.uk

Please note that names and other identifying data have been altered in both this summary, and the original paper.

The research reported on a small group study (n=10), utilising pre-test, post-test self assessment scales Beck Depression Inventory-2 (BDI-2) and follow up interviews to explore the effectiveness of using Solution Focused Therapy with people diagnosed, using the BDI-2, as being moderately to severely depressed. All clients had been referred to Barnsley PCT Department of Psychology by either their GP or a sector mental health team.

Clients in the study that completed post intervention BDI-2 self assessment questionnaires (n=7) reported a mean average improvement of 55.12%, in the range of 19.23%
(lowest improvement) to 93%
(highest improvement).

Additionally, follow up interview (not conducted by therapist / researcher) enabled the study to examine further, different SFT interventions that were found to be the most and least helpful.

Focus

The author's main experience as a therapist had been primarily, until this research, with a particular client group, alcohol and substance misusers.

The author felt that working with a different client group would allow him to practice SFBT without combining it with other interventions that he had utilised in drug and
alcohol work (Hanton, 2003), thus adding internal validity to the
findings.

As well as quantitative data the author wanted to gain client experience of the therapy as an aid to reflective practice. It was therefore decided to combine quantitative and qualitative methods of research (bricolage) in order to identify any positive change, and to gather the client's views on what, if anything had been helpful.

The description by McLeod (2000) of 'researcher as bricoleur' or the 'bricolage' approach to research as proposed by Denzin & Lincoln (2000) was encouraging and wholly appropriate as it seemed to allow a great deal of flexibility in what seemed a very uncertain journey (Elliot & Williams, 2001).

Existing research base and literature review

In looking for any research undertaken into SFBT and depression, or indeed any SFBT research, known Solution Focused Brief Therapy websites were visited. The author was already aware of the review of solution focused outcome research carried out by Gingerich & Eisengart (1999) http://www.gingerich.net.

On revisiting the Gingerich website in September of 2004 it became apparent that Professor Gingerich had added another study (Bozeman, 1999) and had divided the known research studies into three categories; Strong, moderate and weak. Both Sundstrom (1993) and Bozeman (1999) appear in the 'Strongly-Controlled Studies' section with short descriptions.

A full chapter is dedicated to the research base and literature review in the original paper, essential points only are given here.

As a member of the largest Solution-focused message board on the Internet http://www.sft-l@maelstrom.stjohns.edu/cgi/wa.exe the author posted a request regarding any knowledge of SFBT research into depression.

One response was received and gave the email address of the Social Insurance Institution in Finland which was/is conducting an ongoing study of psychotherapy outcomes; The Institute sent the results to date.

This study was/is a longitudinal study exploring the effectiveness of; long and short term psychodynamic therapies, Solution Focused Therapy and Psychoanalytic therapy on anxiety and depressive disorders (n=367). The study is ongoing in regards to the longer term psychodynamic therapy and psychoanalytic therapy, though the findings regarding SFT (n=93) and short term psychodynamic therapy (n=98), over a 12 month period, had been published (Knet & Lindfors, 2004). The authors concluded that both

SFT and the short term psychodynamic therapy groups saw an alleviation of symptoms, improvements in BDI scores and improvement in work ability and social functioning, so were effective in treating depression, neither therapy showed any notable differences in outcomes.

Dr Alasdair Macdonald's chapter on SFBT research in Handbook of Solution Focused Therapy (O' Connell & Palmer, 2003), lists a total of 32 pieces of known, published SFBT research. Macdonald (2003) differs from Gingerich (2000) in what can be seen as strong studies, however, both list Sundstrom (1993) and Bozeman (1999).

Apart from the two, unpublished studies cited on the Gingerich website and the Helsinki study (Knet & Lindfors, 2004); no other existing literature on SFBT and depression existed at the time of the research.

Finally, it is interesting to note that George, Iveson & Ratner (1998) talk of three stages or phases of research in therapy. Stage one is the simple customer satisfaction survey, employed by many agencies and individual therapists, at the end of sessions, end of therapy or as a follow-up. Stage two employs before and after measures, this study sits firmly here. Stage three would be comparison and larger studies, of which, at the time of writing (1999), there were none.

Method

Practitioner research.

'Methodologically pluralistic, using quantative and qualitative methods as appropriate' (McLeod, 1999, p.10).

In deciding on method, whilst essential that statistical, quantitative evidence for the effectiveness of the therapy was shown, it was also useful to examine the effectiveness of different interventions within the approach, especially those considered as unique to SFBT, again, explored in detail in the original paper.

The study is, in effect, a small group design (n=10) of a correlational nature (Kumar, 1999), employing pre-test, post-test results (BDI-2 is the dependent variable), combined with narratives of the sessions and client recollections of the interventions.

In deciding on methodology, a 'researcher as bricoleur' or 'quilt maker' approach (Denzin & Lincoln, 2000) was taken, employing whatever methods would be most helpful to determining effectiveness in improving practice, (McLeod, 2001). In addition the 'bricolage' approach to research can be seen as most applicable when using SFBT, as both sit within the broad post-modern, social constructionist approach. This approach is well suited to researchers that are primarily therapists as it allows an examination of different aspects of the research that may be 'hidden' by adhering strictly to a particular school of methodology. It can be argued that, as well as the production of Quantitative data, this approach also encourages creativity, ownership, and exploration.

The 'bricolage' approach to research is becoming more widely recognised as a valid approach in psychotherapy research, though sometimes unpopular with academic institutions (Denzin & Lincoln, 2000).

In using this approach, Bergin & Garfield (1994) state:

"We find ourselves endorsing a kind of pluralism that does not throw out the virtues of the traditional approaches to research, but complements those with a variety of more flexible techniques for getting at the complexity of the phenomena we deal with." p.828.

Authors (Davydd & Levin, 2000), (Denzin & Lincoln, 2000) talk of the emerging trend of combining methods to make meaning of therapeutic research.

It is worthy of note that the founders of SFT in Milwaukee have always favoured reflection on practice and client feedback to academic method (DeJong & Berg, 2002).

A research proposal was submitted to Birmingham University and Barnsley Department of Psychology. Once approved this was submitted to the Barnsley Ethics and Research Committee. Having gained the approvals required the author/researcher undertook to be on placement as a trainee therapist under supervision within the Dept. of Psychology.

At the time of being involved as a 'trainee' with the Department, the author had over 1000 hours of supervised therapeutic practice, other 'trainees' to the department were generally students on placement on a postgraduate CBT course, or clinical psychology trainees with many less hours. The reason for noting this is simply to recognise the status that SFBT currently has in relation to other approaches utilised in statutory services; this may be, in part, due to the lack of a formal accreditation route for SFBT in the UK.

For the research, a total of ten clients were offered a maximum of eight sessions. This figure (10) was chosen as it represented a small group design that could be easily used in the numerical processes required for the Quantitative element of the research.

It should be noted that this small sample does not lend itself to any conclusions of statistical evidence. The research did however demonstrate a richer description of client experience than purely statistical methods might, and, in addition, provided a more detailed narrative of the sessions and any significant moments (Bluff, 1997), (Kazdin A.E., 1994).

The head of Barnsley PCT Department of Psychology and the Lead Psychotherapist selected all clients on the waiting list due to be allocated an initial appointment, post assessment, that had BDI-2 scores within the range 25-32, which indicates moderate to severe depression (Groth - Marnet, 1999).

The use of the BDI-2 adds both internal and external validity to the research, as the BDI (1st and 2nd versions) is seen as one of the most widely utilised assessment and research tools (Kazdin, 1994), (Kumar, 1991), (Lambert, 1992), (McLeod, 2003).

Clients that consented were asked if they would be willing for the sessions to be video or audiotaped. The main purpose of which was for confirmation of adherence to the solution focused approach(es) in conducting the sessions as outlined in the EBTA research protocol. The video/audio tapes also acted as an invaluable resource for both the supervisor and therapist in the supervision process (Dryden & Feltham, 1992).

The clients also agreed to have a follow up interview at the department approximately six to eight weeks after their last session, for the dual purpose of gaining post intervention BDI-2 scores (quantitative) and any recollections of what had been most and least helpful (qualitative).

Results

Post intervention, the clients self assessed again and a new BDI-2 was recorded. Clients were also asked qualitative questions and invited to talk about anything else of relevance, this, combined with elements of discourse from sessions, led to a rich

narrative that helps give the reader some insight into the therapeutic experience and process.

Eight clients completed the amount of sessions that they felt they needed, so had planned discharges. One client dropped out of the study after attending five sessions, and one dropped out after the first session, this is explored in the original paper as is the client that had fourteen sessions.

The ten clients had a total of fifty three sessions, ranging from one session to fourteen sessions, the mean amount of sessions being 5.3.

The clients were aged 21 to 64, the average mean age being 34.5 (all client ages divided by 10).

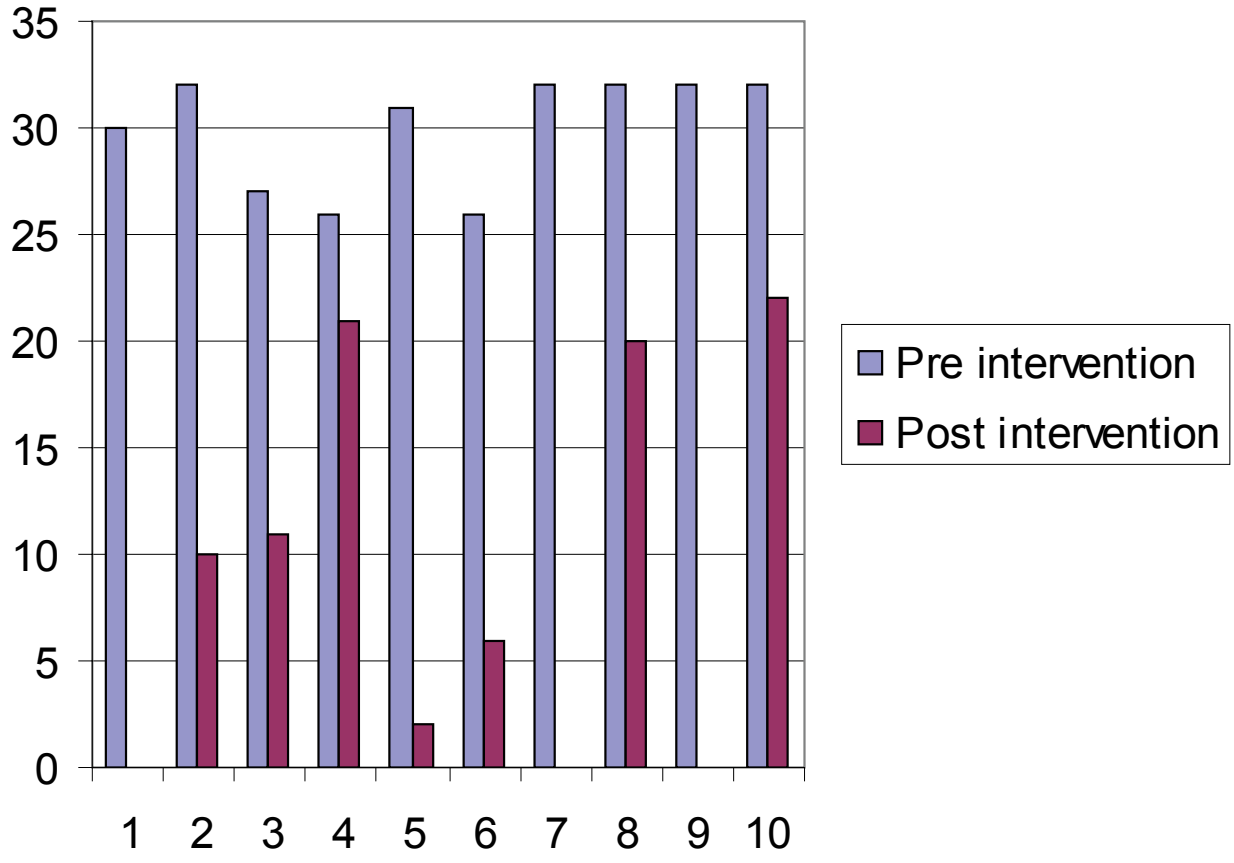
Six clients were female and four clients were male. All clients were white and resided in the Metropolitan Borough of Barnsley, South Yorkshire. The ten clients that attended sessions were identity coded from 01 – 10.

Pre and post-therapy BDI-2 scores are shown below along with the average pre and post therapy BDI-2 scores, and the average improvement scores.

Pre and post BDI Scores.

Average pre intervention BDI score.
The sum total of all clients' BDI-2 scores at first assessment (a) were divided by ten (total clients) (b) giving the following mean score:
a / b = 30, with the range between 26 and 32.

However, as only seven clients completed post test



BDI-2 scores; the sum total of those seven clients BDI-2 scores at first assessment (a) were divided by seven (total clients) (b) giving the following mean score:
a / b = 29.42, with the range between 26 and 32.

Average post intervention BDI score.
The sum total of all post intervention BDI-2 scores (d=90), were divided by total clients completing BDI scores post intervention (c=7) giving the following mean score d / c = 12.87

Improvement range.

Clearly some clients showed more improvement that others, the least improvement shown was five points (19.23%) and the greatest improvement shown was twenty nine points (93%).

The mean average improvement defined by BDI-2 points (all point differences divided by seven) = 16.28.

The mean average percentage improvement (all percentage differences divided by seven) is 55.12%.

It was also possible to define the results further and calculate percentage improvement for each individual client by taking the pre-test BDI-2 score as a value of 100%, with each improvement point (BDI-2) being given a percentage value; this is illustrated in the original paper.

Post intervention interviews.

Clients were asked to scale each intervention (describing the intervention type if needed) if remembered, from 0 to 10; 0 being not at all useful/helpful and 10 being most useful/helpful. In addition clients were invited to comment on each intervention and to give any additional feedback, which they thought was of relevance; this is explored in full in the original paper. In short, the factors (averaged) that were seen to be most useful were; General talking, relationship with the therapist, looking to the future, and therapist praise (all averaging above 8). The least useful interventions (averaging below 4) were; end of session break and post break feedback.

Discussion

The quantitative data stands for itself, though in the conclusion there are comments relating to this. Indeed, the examination of the quantitative data alone, may tell the reader that people got better and that they saw a solution-focused therapist, but little of how and why they got better, or what helped.

Authors of counselling and psychotherapy research texts talk of the 'rich narrative' and the interpretation and exploration of the narrative as interesting in such research (Bluff, 1997), (Kazdin A.E., 1994). Whilst quantitative methods have real validity in measuring change, it is arguable that in this field of research, number crunching is less important than the analysis of narrative, which can lead to subtle modifications of the therapists approach.

Quantitative data alone is quite superficial to the reader unless used in conjunction with the narrative of the sessions, McLeod (2003) states unequivocally:

"It is meaningless to report only Behavioral measures or test scores in a case study without also including a narrative account of the client, the treatment and other background factors." P.108.

It is not possible within this summary to detail the whole of each or any session as might be done within a single case study design. However the original paper does look at the narrative of the therapeutic sessions, paying particular attention to specific solution focused approaches, and any defining moments in the therapeutic process for both client and practitioner.

Conclusion

The study shows that the 7 people that completed

the post intervention BDI-2 achieved lower post intervention scores; all clients reported feeling better, or less depressed.

That 70% of all clients completed follow up BDI-2's compares well with the expectation that only 50-60% (McLeod, 1999) would do so. This is even more impressive when one realises that of the 8 people that successfully completed treatment, 7 completed BDI-2's, or 87.3%.

It was not possible to analyse - academically - the clients experience as was hoped due to the amount of clients that did not attend a follow-up interview, this is explored in the original paper as is an examination of extra therapeutic factors as outlined by Lambert (1992). However, from comments received it is clear that feeling 'at ease' with the relationship, looking to the future and positive reflection on achievements were found to be helpful.

The author closely followed the EBTA research protocol which adds external validity to the paper, as does the use of the BDI-2 at pre and post intervention (Kazdin, 1994), (Kumar, 1991), (Lambert, 1992), (McLeod, 2003). The largest outcome study (Knet & Lindfors, 2004) being undertaken into SFBT outcomes also utilises the Beck Depression Inventory.

The research would count as a 'moderately controlled study' in that it meets 4 of the 6 standards outlined on the Gingerich website http://www.gingerich.net. One of two, additional standards would have determined it as a 'strongly controlled study'. The two standards not adhered to are; (3) compares SFBT with a standard reference treatment, placebo or no treatment, and (6) uses a sample large enough to reliably detect group differences.

In relation to the 'stages' of research suggested by George, Iveson & Ratner (1998), this paper sits within 'Stage 2' in that it employs pre and post test measures.

There are limitations in this study that need to be highlighted here and are examined in more detail in the original paper:

- The small sample of seven (completers) cannot be seen as statistically significant.
- The study did not make any comparison with clients participating in other therapies or no therapy.
- The study did not have a cultural or ethnic mix other than white English.
- The study did not follow up any longer than six to eight weeks post last intervention.

The research is internally valid, in that all procedures, method, and interventions were carefully checked and rechecked. The external validity can be confirmed against the known research protocols, research and assessment tools, existing literature and existing research.

It is reasonable to conclude from this study four things:

1. SFBT has no detrimental effect when working with clients diagnosed as moderately to severely depressed.
2. All clients that completed therapy showed improvement in symptoms.
3. Clients attributed some specific SFBT interventions as being more helpful or influential in their improvement.
4. SFBT is effective in working with people with moderate to severe depression.

The study, being based in therapeutic practice has enabled the author, to hone practice and this is also explored in the original paper.
In conclusion, whilst this study had an academic purpose in that it contributes to the pool of evidence in SFBT research, the author/therapist feels that the real benefit will be to future clients, and that was always the motivation.

Bibliography

Bachelor, A. & Howarth, A. (1999), The therapeutic relationship, In Hubble, M.A., Duncan,

Beck, A.T., Ward, C.H., Mendelson, M. et al (1961), Inventory for measuring depression, Archives of general psychiatry, 4:561-71

Bergin, A.E. & Garfield, S.L. (1994), Overview, trends and future issues, In Bergin, A.E. & Garfield, S.L. (eds.), (1994), Handbook of Psychotherapy and Behaviour Change, Sage, New York

Bluff, R. (1997), Evaluating qualitative research, British Journal of Midwifery, Vol.5, No 4, Southampton

Bozeman, B.N. (1999), The efficacy of solution-focused therapy techniques on perceptions of hope in clients with depressive symptoms, unpublished doctoral dissertation, New Orleans. IA.

Davydd, J.G. & Levin, M. (2000), Reconstructing the relationships between Universities and Society through action research, In Denzin N.K. & Lincoln, Y.S. (eds), (2000) Handbook of qualitative research, 2nd edition, Sage, California

Denzin N.K. & Lincoln, Y.S. (2000), The discipline and practice of qualitative research, In Denzin N.K. & Lincoln, Y.S. (eds), (2000), Handbook of qualitative research, 2nd edition, Sage, California

Elliot, M.S. and Williams, D. (2001), Paradoxes of qualitative research, In Counselling and Psychotherapy research, Volume 1, no 3, p181-183, BACP, Rugby

George, E., Iveson, C., Ratner, H. (1999), Problem to Solution, 2nd edition, Brief Therapy Press, London

Gingerich, W.J. & Eisengart, S. (1999), Solution Focused-Brief Therapy: A review of the outcome research, Western Reserve University, Ohio

Gingerich, W.J. & Eisengart, S. (2000), Solution Focused-Brief Therapy: A review of the outcome research, Family Process, 39:477-498

Groth-Marnet, G. (1990), The handbook of psychological assessment (2nd ed.), John Wiley & Sons, New York

Hanton, P. (2003), Solution-Focused Therapy and Substance Misuse, In O'Connell, B. & Palmer, S. (2003), Handbook of Solution-Focused Therapy

Kazdin, A.E. (1994), Methodology, design and evaluation in psychotherapy research, In Bergin, A.E. & Garfield, S.L. (eds.), (1994), Handbook of Psychotherapy and Behaviour Change, Sage, New York

Knet, P & Lindfors O. (Eds.), (2004), A randomized trial of the effect of four forms of psychotherapy on depressive and anxiety disorders, Edita Prima Ltd., Helsinki

Koss, M.P. & Shiang, J. (1994), Research on brief psychotherapy, In Bergin, A.E. & Garfield, S.L. (eds.), (1994), Handbook of Psychotherapy and Behaviour Change, Sage, New York

Kumar, R. (1999), Research Methodology: A step-by-step guide for beginners, Sage, London Lambert, M.J. (1992), Psychotherapy outcomes research: Implications for integrative and eclectic therapists, In Norcross, J.C. & Goldfried, M.R. (eds.), (1992), Basic Books, New York

Macdonald, A.J. (2003), Research in Solution-Focused Brief Therapy, In O'Connell, B. & Palmer, S. (2003), Handbook of Solution-Focused Therapy McLeod, J. (1999), Practitioner research in counselling, Sage, London

McLeod, J. (2000), Qualitative inquiry in action: Researcher as 'bricoleur', Paper presented at the Society for Psychotherapy Research, Annual conference 2000, Chicago

McLeod, J. (2001), Qualitative research in counselling and psychotherapy, Sage, London

McLeod, J. (2003), Doing counselling research, 2nd edition, Sage, London

Miller, S.D., Duncan, B.A. and Hubble, M.A. (1997), Escape from Babel,
Toward a Unifying Language for Psychotherapy Practice, Norton Press, New York

O'Connell, B. (1998), Solution-Focused Therapy, Sage, London

O'Hanlon, W.H. and Weiner-Davis, M. (1989), In Search of Solutions, A new Direction in Psychotherapy, Norton Press, New York

Sundstrom, S.M. (1993), Single-session psychotherapy for depression: Is it better to focus on problems or solutions? Unpublished doctoral dissertation, Iowa State University, Arnes, IA.

Websites

Please note, all the websites listed have been accessed numerous times.

Brief Therapy Practice.
http://www.briftherapy.org.uk/

European Brief Therapy Association.
http://www.ebta.nu/

Gingerich, W.A.
http://www.gingerich.net

Google search engine.
http://www.google.com

Institute for the study of therapeutic change.
http://www.talkingcure.com

Korman, H., Solution Focus list.
http://sft-l@maelstrom.stjohns.edu

Macdonald, A.J.
http://www.psychsft.freeserve.co.uk

Milwaukee Family Therapy Center (sic).
http://www.brief-therapy.org/