Examination of the Application of Solution Focused Therapy at Family Services of Winnipeg

By Sharlynne Burke

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EXAMINATION OF THE APPLICATION OF SOLUTION FOCUSED THERAPY AT FAMILY SERVICES OF WINNIPEG

BY

SHARLYNNE BURKE

A practicum submitted to the Faculty of Graduate Studies of the University of Manitoba in partial fulfillment of the requirements of the degree of

MASTER OF SOCIAL WORK

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PREFACE

I was very fortunate to have the opportunity to serve as a research evaluator for Family Services of Winnipeg Inc. This paper describes the process of this learning experience. I was invited into a social service agency that differed enormously from the clinical setting in which I practice as a nurse therapist, being introduced to an innovative therapeutic approach that challenged my knowledge base of interpretive therapy.

The evaluation of one's clinical practice is theoretically sound, but seldom ventured. It is the student's professional experience that scrutiny of treatment process and outcome is often placed on the back-burner by service providers. When treatment success is described, it is either impressionist or anecdotal, with little or no empirical evidence to support clinical observations. Therefore it was refreshing and enlightening to be introduced to professionals who were interested in and willing to participate in learning more about the impact of their therapeutic interventions.

CHAPTER 1

INTRODUCTION

This practicum report chronicles the student's experiential journey as a formative evaluator at Family Services of Winnipeg Inc. (FSI). The original intent of this practicum was to measure the "effectiveness" of Solution Focused Therapy (SFT). As the research concepts were operationalized, questions arose that were related to treatment delivery and consistency. What started out as treatment evaluation evolved into an examination of the application of SFT. To best prepare for this role, the student borrowed from the literature of research and program evaluation.

Lind and O'Brian (1971) identified the emergence of program evaluation in the late 1960's as an effort to "prove" the value of the numerous treatment interventions. This need for "proof" extends to all levels of service delivery, i.e. to those who provide the service, receive the service, and finance the service. Concerns continue to be expressed by both providers and consumers as to the quality of health care services available. There is a need to identify service gaps, and to assess if available services meet the demands of the consumer. "Programs that fail to demonstrate their effectiveness are ultimately vulnerable to public criticism and loss of support" (Pietrzak, Ramler, Renner, Ford & Gilbert, 1990).

In Canada, universal health care has historically represented a large and increasing, although socially laudable, drain on the economy. During this decade of "restraint", the movement away from lengthy treatment approaches is, in part, a response to the economic and social reforms inundating our society.

As clinicians we face the culmination of the competing forces of consumer demands and fiscal restraint that compel social agencies to become more cost effective and improve service delivery. If we, as clinicians, uphold the value that the consumer is entitled to receive effective treatment at the least cost to the system, a mechanism for evaluation of clinical practice is imperative. Service duplication and lengthy ineffectual treatment, besides being theoretically unsatisfactory, are subject to financial constraints (Slonim-Nevo & Vosler, 1991; Lind & O'Brian, 1971). It has been the student's experience that mental health service delivery lacks this on-going monitoring of accountability. "The assessment of direct practice with individuals and families has generally remained fragmented in conceptualization and unsystematic in application" (Trute, 1985).

Overview of the Practicum

The goal of this practicum was to introduce the student to evaluation research through the experiential role as a formative

evaluator. Through this role the student gained both a theoretical and experiential knowledge base in (a) the process of clinical evaluation, (b) research design and implementation, and (c) Solution Focused Therapy.

This practicum report is divided into three components. The first component of this report addresses the experiences that the student had as a formative research evaluator. Chapters 2 and 3 comprise the literature review. Chapter 4 outlines the process of creating the parameters used to examine SFT. The student assisted the therapists in incorporating the research goals into the existing agency mandate and therapy goals.

The second component of this practicum addresses the process of treatment delivery. Included in Chapter 5 is an objective observational tool developed by the student to provide and assess treatment integrity across therapists and time. Semi-structured interviews were developed to: (a) enhance the observational tool, (b) better understand the expressed therapists concerns of the SFT model, and (c) explore the models "fit" with the therapists.

Chapter 6 discusses the third component of this practicum, the treatment effectiveness of Solution Focused Therapy. Included is the development and implementation of the research design. The findings

are first presented as a general overview and then by single-system analysis. The chapter concludes with a case-by-case discussion with speculation as to the understanding of the findings. Suggestions are made throughout for future research considerations.

Chapter 7 reviews the attainment of the research goals. The student shares her experiences and briefly discusses the inherent difficulties of research evaluation.

CHAPTER 2

PROGRAM EVALUATION

This chapter on program evaluation provides a general understanding of the concept, the differing roles of an evaluator, and the framework that guided this student's experiences as a formative evaluator at Family Services Inc.

What is Program Evaluation ?

Program evaluation is applied social science research. Rossi and Freeman (1989) stated that program evaluation must include program design, on-going monitoring, assessment of impact, and cost/benefit analyses. Evaluating the effectiveness of a treatment intervention requires the consideration of both immediate and long-term outcomes and of financial, temporal, and other costs (Kazdin & Wilson, 1978).

Program evaluation includes the analysis of the system as a whole, or parts of that system. Pietrzak et al. (1990) described three types of evaluations that may be used: input, process or outcome. Input evaluations focus on the "raw materials" of the system. This includes the clients, staff and resources. Process evaluation focuses on the internal dynamics and the delivery of service to the clients, while the impact or effect of the process is evaluated by outcome measures. For purposes of this practicum report the student presented these theoretical constructs

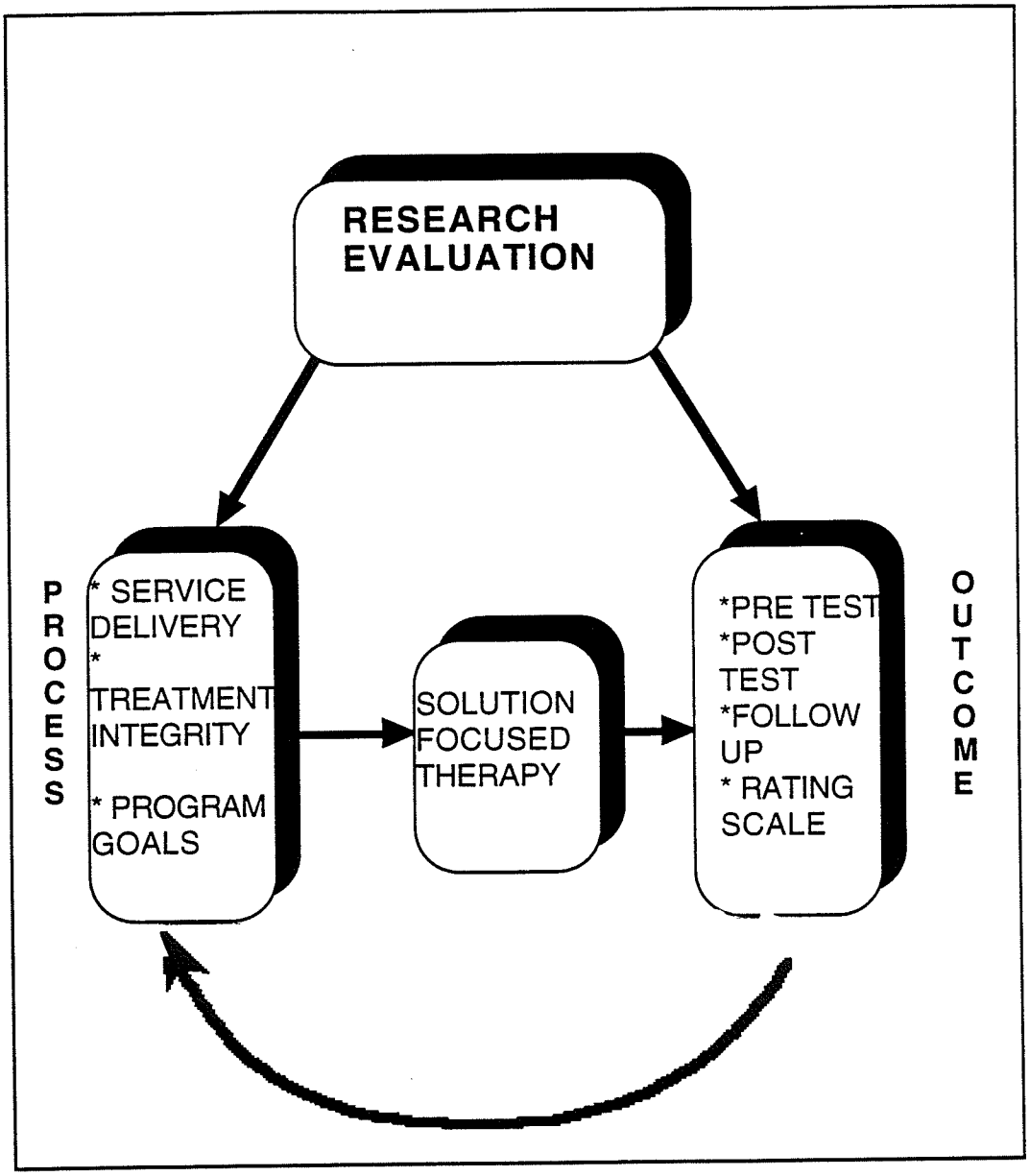
as independently as possible. However, in the clinical application of service delivery, the sub-systems of a program are simultaneously autonomous and interactive. Their boundaries are permeable and the interactive processes are circular in nature.

The information generated from program evaluations may provide data to assist in the decision making process of a service, to identify service gaps and weaknesses, or to assess the effectiveness or impact of new or existing programs.

Within the spectrum of evaluation research, the student examined the application of SFT at FSI (see figure 1). This practicum focused on creating methods for consistent delivery of the first session (process) and the effectiveness of the intervention (outcome).

FIGURE 1. Diagram of Research Evaluation Process

Measures of program success included treatment success and consistent delivery of the first session.



Role of the Program Evaluator

Figure 2 compares the summative and formative roles of the program evaluator as described in *The Evaluators Handbook* (Herman, Morris, & Fitz-Gibbon, 1987). The differentiating features include the: (a) type of data collection and analysis, (b) relationships with developers and implementors, and (c) implications of the findings. The role of the summative evaluator allows little room for a creative process whereas the formative evaluator is allowed flexibility in research design (Bloom & Fischer, 1982). The process for both summative and formative evaluation as described may be broken down into four phases of planning that address: (a) the parameters of the evaluation, (b) the method of evaluation, (c) the collection and analysis of the data, and (d) the reporting of findings.

Herman, Morris and Fitz-Gibbon (1987) suggested that an evaluator should begin to research the agency from the time of initial contact. This information gathering should be an ongoing process, and should be continued throughout the planning phase. A positive working relationship with those involved is of paramount importance, and the authors identified trust, cooperation, and ownership as key elements. The working relationship should allow identification of: (a) program goals, (b) problems in the program, and (c) potential pitfalls. This would

FIGURE 2. The Roles of a Formative and Summative Evaluator

Adapted from *The Evaluators Handbook* (Herman, Morris, & Fitz-Gibbon, 1987).

COMPARATIVE EMPHASIS :FORMATIVE VS SUMMATIVE EVALUATION		
Primary Audience	*program developers * program managers *program implementors	*policy makers *funders *interested publics
Primary Emphasis in data collection	*clarification of goals *the nature of program process/implementation *clarification of problems in implementation and in progress of outcomes, *micro-level analyses of implementations and outcomes	*documentation of outcomes * documentation of implementation * macro-level of analyses of implementation and outcomes
Primary role of evaluator	* interactive	* independent
Typical methodology	* qualitative and quantitative, with more emphasis on former	* quantitative, sometimes enriched with qualitative
Frequency of data collection	* ongoing monitoring	* limited
Primary reporting mechanisms	*discussion/meetings informal interaction	* formal reports
Reporting frequency	* frequent throughout	* at conclusion
Emphasis in reporting	* relations among process elements- micro level * relations among context and process * relation between process and outcome * implications for program practices and specific changes in operations	* macro - relations context process outcome * implications for policy, administrative controls and management
Requirements for credibility	* understanding of program * rapport with developers / implementors * advocacy / trust	* scientific rigor * impartiality

assist in the evaluation plans and process. The involvement with staff from the inception of the evaluation study would increase the likelihood of cooperation in all phases with the added benefit of the knowledge base provided by the staff members. Therefore, it was imperative for this student in the role of a formative evaluator, to learn about Solution Focused Therapy.

To prepare for the initial meeting at FSI, the student familiarized herself with SFT by reading books and articles written by Steve de Shazer. The student's education and information gathering on SFT continued throughout the course of the practicum. The student attended workshops on SFT that proved to be especially important to meet the challenges of an evolving process.

The following chapter will provide a succinct overview of SFT and the history of the brief therapies as they plant the ground for the development of this innovative intervention.

CHAPTER 3

SOLUTION FOCUSED THERAPY

Historical Genesis of Brief Therapies

The development of the brief therapies appeared to emerge as a response to the economic and social reforms of the time. Impacting on these developments were the influences of separate, yet related fields of mental health research and theory. These included the child guidance movement, group therapy, family therapy and crisis intervention model. Leopold Bellack in his introduction to Leonard Small (1971) stated:

> Community Mental Health perforce becomes an important part of community health in general. It is part of the economic situation and part of the problems of the body politic, as it plays a role in every facet of daily community life. Primary prevention and very early secondary prevention will have to play an increasing role in mental health care. The briefer psychotherapies are ideally suited to this need.

This statement made more than two decades ago, is as relevant to our day as it was then. Literature of the 1960's, 70's and 80's described brief therapies as an "off shoot" to consumer demands. What constituted "brief" changed dramatically through the decades. Small's research indicated that "brief" was anywhere between 1 to 217 sessions (1971). Many definitions of brief therapy have referred exclusively to treatment that extended from 1 to 25 sessions (Fisher, 1980; Koss & Butcher, 1986). It has been this student's experience that in todays' mental health

climate "long-term" translates into more than six months, while "brief" treatment is typically viewed as ten sessions or less. Budman and Gurman (1988) in their book *Theory and Practice of Brief Therapy* argue that the brief therapies have always been present by "default". They suggest that brief therapy should not be defined by the number or length of sessions but be viewed as the therapist assisting the consumer to achieve maximum benefit with the lowest investment of therapist time and consumer cost. These costs to the consumer are both psychological and financial.

Brief therapy was grounded in the psychodynamic theories. Psychoanalysis was a theoretical breakthrough at the turn of the century. In the early days of the psychoanalytic movement it was a generally held view that therapeutic interventions should be concise (Marmor, 1979). Thus therapy, although not coined as "brief", was in practice a short term endeavor. "Freud believed that to know the cause of the neurosis would lead promptly to it's solution and resolution" (Small, 1971). As the study and treatment of the mind grew, analytic thinking became more refined. Thus the more the analyst delved into the psyche, the more complex were the problems. The cornerstone of psychoanalysis and of other dynamic psychotherapies was the fostering and analyzing of the patient's "transference" towards the therapist (Nichols, 1984). "As the goals of analysis became increasingly more ambitious (it was) that treatment

became longer, and longer" (Budman & Gurman, 1988). Analysts at that time vied for a more efficient approach, with Freud setting the more orthodox tone. Not until after Freud's death in 1939, did brief treatment approaches reemerge.

French and Alexander published their work on brief treatments in 1946. This was in response to the immense number of World War II veterans who required treatment for "war neuroses and battle fatigue". French and Alexander discussed "creating a corrective emotional experience" for the client (Budman & Gurman, 1988). Coinciding with their work was the emergence of the crisis intervention model created by Witner in Boston. It was the clinical understanding that a relationship formed in crisis would be “fruitful” (Budman & Gurman, 1983). In the latter 1960's and early 70's, Mann developed 12-hour therapeutic techniques that were based on the principles of psychoanalysis (Nichols, 1984). These approaches focused exclusively on the individual as a consumer of services.

Of major importance to the development of the brief therapies was the emergence and influence of family therapy. Family therapy had its genesis in the social science research of the 1920's. That in turn paved the way towards the emergence of group psychotherapy in the 1930's. Coinciding with this focus on group dynamics, was the growth of the child

guidance movement that "concluded that the child's symptoms had their sources from the family tensions'" and helped form the "team approach to family therapy" (Nichols, 1984). John Bell, influenced by the group therapy treatment approach, encouraged open discussion among family members and may be considered the "first family therapist" (Nichols, 1984).

The two most utilized psychotherapy approaches in the 1950's were client-centered therapy and psycho-analysis (Nichols, 1984). Research that linked the development of schizophrenia to family life was the main focus of those decades. Recognizing the inter-relatedness of the illness and the pathogenic family, the prevailing practice was to isolate the patient from the family.

As clinical expertise, research and theoretical developments expanded, the search for underlying dynamics to explain the family were undertaken. It was during this time that working independently in Palo Alto, California, Gregory Bateson and Don Jackson pioneered the use of family therapy. Bateson, who focused predominately on research of the study of communication, "stumbled" on the treatment of these families during naturalist observation (Nichols, 1984). Actively involved at the clinical end, Jackson and colleague Jay Haley, focused on the dynamics of interchange between family members. The family was viewed as a

system that moved towards the maintenance of homeostasis as an understanding of the "nature and purpose" of family interaction (Nichols, 1984). Jackson's 1954 paper on "homeostasis", and later work on the theory of "double bind" were just the beginning of a marriage that would link theoretical understandings to therapeutic techniques and interventions of family therapy.

In the 1970's John Weakland and colleagues of the Mental Research Institute began to expand from their roots in psychodynamic understanding and unite the theoretical constructs of family therapy and behavior modification (Weakland, Fisch, Watzlawick & Bodin, 1974). Their theoretical construct looked at ordinary life cycle transitions as having turned into problems when they were either over or under emphasized, and thus not handled adequately by the family. The therapeutic intervention focused on observable behavior and deliberate interventions to alter the system. Weakland et al. (1974) believed that minor changes in overt behavior, or "verbal labeling" would be sufficient to solicit change. Following a format that outlined: (a) the definition of the problem in concrete terms, (b) investigation of solutions attempted, (c) clear definition of concrete change to be achieved, and (d) formulation and implementation of the plan, one could see how the foundation for Solution Focused Therapy had been laid.

Impacting on this movement that rejected much of the psychoanalytical understanding, was the sociopolitical climate that preached an increase in accessibility to psychotherapeutic services and emphasis on the "quality of life" (Lind & O'Brian, 1971). The growth spurt of the brief therapies in the 1960's was in response to social change. The 1970's saw the development of the Community Mental Health Movement (Small, 1971). No longer would the "elitist" luxury of long-term psychoanalysis be tolerated. The prevailing social consciousness was egalitarianism. Koss and Butcher (1986) identified four factors that led to the movement away from the more traditional models of long term psychotherapy: (a) clients would typically seek treatment for specific problems and thus anticipated a brief course of treatment, (b) the brief therapies were thought to be effective with both acute and chronic problems, (c) brief therapies were found to have the same rates of success as long-term therapy, and (d) insurance companies and health programs that limit financial payments would support a shorter treatment period.

Brief Therapy Theoretical Underpinnings

Brief therapy differs from the traditional psychotherapies in philosophical understanding. In brief therapy a search for insight into the cause of the presenting problems is not pursued. Rather the focus is upon goals, and viewing problems as being interactional in nature

(O'Hanlon & Weiner-Davis, 1989). Budman and Gurman (1983) detailed the assumptions of brief therapy as follows: (a) change is not just possible but inevitable, (b) problems dealt with in therapy are those defined by the client, and (c) the "real" world outside is the most important part of the client's life. The underlying theoretical belief draws upon the teachings of Milton Erickson. Erickson's premise was that the client had the resources within to tackle the problems that faced them. The role of the therapist was to assist the client in accessing theses resources (de Shazer, 1986; O'Hanlon & Weiner-Davis, 1989). Following Erickson, problem-focused brief therapy placed the emphasis on the "how to solve" versus the root or "cause" of the problem.

Brief Therapies Research

Literature indicates that brief treatment approaches have been used successfully in individual, marital and family therapy. Fisher (1980), using a population of families that attended a child guidance clinic, compared time-limited brief therapies and unlimited-time therapies to a waiting-list control group. The brief therapies did not extend beyond 12 sessions. Outcome measures obtained from 37 families, were extensive and included behavioral checklists, self-assessment tools, the measuring of mood and family process, as well as outside observational measures. They were administered to the family members at intake, after six sessions, at termination, and at a six week follow-up session. The

study concluded that "time-limited therapy was no better or worse than unlimited treatment", and that "no measurable advantage was found when therapy was continued beyond six sessions".

Fisher (1984) attempted to address the durability of brief treatment by administering a one year follow-up study using the same families in his 1980 study. This follow-up study indicated that for "some families" brief treatment was an "effective and durable approach".

John Weakland, Richard Fisch, and Paul Watzlawick, based at the Mental Research Institute (MRI) in Palo Alto, indicated that clients made significant improvement or reached treatment goals in less than ten sessions (Weakland et al., 1974). This study, conducted at the Brief Therapy Center, was mentioned frequently in the literature reviewed by the student (de Shazer et al., 1986; Slovin-Nevo, 1991). The research subjects ranged from age five to sixty years, and were from differing ethnic origins and economic strata. They presented a variety of reasons for seeking help. The therapeutic intervention, as touched upon earlier in this paper, followed a ten session, six stage schema. The 97 cases generated were comprised of 236 individuals being seen for individual, couple or family therapy. The average number of sessions was seven. Treatment was considered successful with 40% of the cases, 32% indicated significant improvement, and 28% were considered treatment

failures. Treatment success was determined by observation of the subjects for objective markers and follow-up interviews. Considering evaluation as a systematic comparison of treatment and behavior change to the main presenting problems, Weakland et al. (1974) concluded that "we feel fairly safe in crediting observed changes to our treatment". The follow-up questions that were asked were: (a) if the treatment goal had been met, (b) the current status of the complaint, and (c) the need for further intervention.

There are few studies specifically addressing the treatment success of SFT. De Shazers' assumptions of treatment success and impact of intervention were primarily impressionistic (Adams, Piercy, & Jurich, 1991). Kiser (1991) examined the relationship between the number of SFT sessions and therapy outcome at the Brief Family Therapy Center. Using a 32 item qualitative consumer feedback form, he contacted 164 clients 6, 12, or 18 months following the termination of therapy. Qualifying treatment success as complete or partial goal attainment, he reported that 72.2% of cases receiving two or more sessions were successful. Further, of those subjects who attended more than four sessions, 90% obtained or partially obtained their treatment goal and made "significantly more progress" than those who received three or less sessions (Kiser, 1991). Although Kiser was cautious in drawing his conclusions due to lack of a control group and threats to

internal validity, he did suggest that SFT was "successful most of the time" (Kiser, 1991). Kiser's preliminary findings do not appear to support de Shazer's incredulous one session cure, however, they do appear to be consistent with brief therapy research. For the student, the more critical questions are what did Kiser really measure and what are the "specific ingredients" of therapeutic change ?

These questions could be addressed by the more rigorous research design of Adams, Piercy and Jurich (1991) to evaluate the effectiveness of SFT. Investigating the Formula First Session Task (FFST) (see following section for further discussion) Adams and colleagues compared the task under controlled conditions to a problem-focused therapy approach. They focused primarily on how the FFST impacted upon the families' compliance to the treatment task, their ability to specify clear treatment goals, and their expectations towards change. Believing that the therapeutic relationship was "bidirectional", the therapists were given the same measures to evaluate goals and expectations towards change. Findings indicated that the families who were given the FFST did comply more readily when compared to those families who were given the problem-focused task. The SFT families reported clearer treatment goals, and problem improvement during the second session. However the authors cautioned against "over-interpreting" their findings. They suggested that FFST was received

more readily by the families as this was behavior already in their repertoire. Secondly, the subjective optimism regarding treatment outcome was no different between the two groups. The instillation of optimism was viewed as a major tenet in the process of change and not a measure of actual outcome.

Development of Solution Focused Therapy

The logical progression from problem focused to solution focused approach appears to be an innovative step taken by the team at the Brief Family Center in Milwaukee. One could perhaps identify Steve de Shazer as the "guru" of SFT. In 1969 de Shazer began the development and use of SFT, and he has continued to refine its format.

Assisting in SFT's theoretical development was the analysis of the "Formula First Session Task" (FFST) intervention that was given at the end of every first session (de Shazer & Molnar, 1987). The FFST statement read: "Between now and the next time we meet, we would like you to observe, so that you can describe to us, what happens in your (fill in) that you want to continue to happen" (de Shazer & Molnar, 1987). As SFT became more concise and structured, expert computer programs were developed to assist the therapist to "model the intervention design process" for the first session (de Shazer & Gingerich, 1991). The task was used with minimal variation over a variety of presenting problems. It

was designed to provide a framework for the client that conveyed from the therapist a belief that something worthwhile was happening, and the therapist expected these worthwhile things would continue to happen (de Shazer & Molnar, 1987). Since the introduction of the FFST in 1982 (Adams, Piercy & Jurich, 1991), alternative intervention tasks have been incorporated into the SFT repertoire. These interventions are determined by the progression of the therapy.

Solution Focused Philosophy and the Concept of Change

The central philosophy of SFT is stated as follows:

1. If it ain't broke - don't fix it
2. Once you know what works - do more of it.
3. If it doesn't work, don't do it again - do something different

(de Shazer & Berg, 1989).

To proponents of SFT, change is perceived as a never ending process (de Shazer, 1991). Thus de Shazer contends that it occurs even before the first session. This change for the client needs to be recognized, and is typically framed in a positive question such as: "What has changed for the better since the time you called?"

De Shazer (1991) surmised that change was promoted when the meaning or label of the problem was renegotiated through the use of

"language games" and was accomplished by the client reframing the original problem. De Shazer and Gingerich (1991) enforced the concept that the problem did not need to be known in order to obtain the solution. Emphasis of exceptions (when the problem did not occur and which implied the presence of a goal) and increasing the frequency of those exceptions led in essence to the construction of the solution. The therapeutic intervention was asking the client to continue to demonstrate the desired behavior. The therapist and client mutually constructed the goals.

In de Shazer's book *Keys to Solution in Brief Therapy* (1985), the theoretical underpinnings of SFT were metaphorically explained. De Shazer described SFT as a skeleton key able to unlock all doors. Therefore understanding of the locks was not needed.

> An intervention only needs to fit in such a way that the solution evolves. It does not need to match the complexity of the lock. Just because the complaint is complicated does not mean that the solution needs to be as complicated
>
> (de Shazer, 1985).

De Shazer's underlying assumption was that the client truly wishes to cooperate with the therapist. Failed interventions or lack of differences were not viewed as client "resistance". Conceptually viewed,

such occurrences were interpreted as the therapist being placed outside of the family system (de Shazer, 1984). If one's clinical perspective was of the family-therapy-as-a-system, the relationship would become cooperative, and thus would endorse the therapist's position of being the one that can promote and expect change (de Shazer, 1984).

One of the therapist's tasks was to create in the client the expectation of problem resolution. That change would happen, and would happen quickly, relied on the therapist (de Shazer, 1985). Kral and Kowalski (1989) remarked that:

> In essence, therapy becomes a matter of utilizing client resources, identifying those exceptions to the rule which are already occurring, creating exceptions when necessary, highlighting the the exceptions and the associated perceptual shifts, and, through the use of "Do more of the Same" techniques, maintaining and generalizing the changes.

The Structure of Solution Focused Therapy

The first session in SFT has been identified as the most important for therapeutic success (de Shazer & Gingerich, 1991). In this session the entrance complaint is described, and therapy goals are set. The first SFT session follows this format: (a) the statement of the complaint, (b) the asking of the miracle question, (c) the intermission-consultation break,

and (d) the delivery of the intervention message from the team. The task given to the client in the first session follows a standard formula and is stated: "Between now and your next session, we want you to observe what happens in your life that you want to continue to have happen" (de Shazer & Gingerich, 1991). Within this structure, SFT therapists utilize a variety of techniques.

First Session Format

Statement of the Complaint

In the first session the therapist ascertains from the client "What can we help you with?", and explores the problems that motivated the client to seek intervention. Before the miracle question was incorporated as part of the format, the detailed gathering of information was used to increase the potential for interventions and goals (de Shazer et al.,1986).

Although SFT de-emphasizes a problem orientation to treatment, active listening by the therapist to the client's entrance problem is considered to be important. The encouraging use of "What else?" allows the client to tell their story, and endorses the development of a relationship between the client and therapist.

Miracle Question

In the earliest stages of SFT, the "crystal ball" question, modeled on the work of Erickson, was used to project the client into a future that was successful. It was believed that such a conceptualization would produce in the client behavior that would enable the client to move towards resolution of the problem (de Shazer, 1985). The crystal ball technique has since been replaced by the miracle question. The miracle question inspires the client to imagine and explore what it would be like if their problems were solved. At the same time it is believed to instill hope. As there is no need to explain a "miracle", the solution focused notion is that questions enhance the development of solutions that are separate from the problems (de Shazer, 1991). The client is encouraged by the therapist to elaborate upon the details of the miracle - the more detail, the more solution possibilities. As the focus of therapy is on generating solutions, and as the miracle question opens the pathway, the problem does need to be known in order for a solution to be obtained (de Shazer & Gingerich, 1991). If the therapist and or the client view the goal as unrealistic, the miracle question is worked until a satisfactory solution is derived.

The establishment of goals provides a concrete format for the measurement of therapeutic progress. Goals are perceived by de Shazer as the "start of something", not the end result (de Shazer, 1991).

Goals increase the client's expectation that change is inevitable. Most crucial is that the goals describe the presence of what will be, rather then merely the absence of the problem. The goals are stated in behavioral terms that are itemized to make them achievable thus enhancing the client's perception of their ability to obtain them. This increases the client's probability of success. The core technique for goal setting is in the form of the "miracle question" (de Shazer, 1988) and is stated as follows:

> Suppose when you go to sleep tonight, a miracle happens and the problems that brought you in here today are solved. But since you are asleep you don't know that the miracle has happened until you wake up tomorrow. What will be different? What will tell you that a miracle has happened?

Follow-up queries that frequently incorporate the significant others in the client's environment are undertaken. To encourage the behavioral goal setting, the therapist's task is to ask questions that would initiate this movement. "What would you have to do to make this miracle happen?"

Exceptions to the Problem

SFT poses a challenge to the problem oriented focus that often becomes ingrained in the minds of those seeking therapy, and those providing the services. The use of the miracle question and the search

for exceptions are tools used by the therapist to challenge the problem focus. Exceptions are described as the times when, either spontaneously or deliberately, the problem behavior is not occurring (de Shazer, 1988). Exceptions are commonly extracted by the therapist after the miracle question has been fully explored. For example: "Are there times now when pieces of the miracle are happening?" When these times are identified by the client, they are probed as to what they are doing "different". Or they may be asked if there are times when the problems do not occur? This is frequently stated in a positive framework, for example, "Are there days when you arrive to work on time?" Exceptions are typically considered by the client to occur on rare occasions. As the therapist actuates attention to the exceptions, the implication is that the client has already started the work towards the resolution of his or her difficulties (de Shazer, 1988, 1991). The therapist is to be on the alert for the client to spontaneously express an exception. This spontaneous event is highlighted verbally by the therapist and explored further. Kral and Kowalski (1989) expounded that "the therapeutic task is to facilitate the exception becoming the rule".

Use of Language

In SFT, language is a therapeutic tool with many dimensions. On one level the client and the therapist have a relationship in which the meaning or label of the problem is renegotiated through the use of

"language games" and "therapeutic misunderstandings" (de Shazer, 1991). The shift of the meaning of words, within the context of the situation, is purported to transform the client's perception of his or her problem. The meaning people attribute to behavior could limit the scope of alternatives they use to handle the given behavior (O'Hanlon & Weiner-Davis, 1989). The example given by de Shazer, described transforming "nymphomania" to "insomnia" (1991). This renegotiation of the problem, through the transformation of the meaning, allowed the client to normalize it and make the problem seem more solvable.

On a more concrete level, SFT encourages the use of language as an avenue to engage the client. As language is the vehicle by which the client portrays their reality, and is the means by which intervention is undertaken, its importance in the therapeutic relationship is paramount. The therapist engages the client by speaking "the same" language, using the same words and idiosyncratic expressions. This conscious behavior on the part of the therapist creates the appearance of a better understanding of the client's reality, and eradicates the "expert position" of the therapist. This was asserted by de Shazer, to have placed the client-therapist relationship more comfortably in the position of cooperation. In the absence of the expert stance, assumptions are not made as to the meaning of words and concepts. As a rule of thumb, the language used by the client is incorporated into the intervention

message given by the therapist (Berg & Miller, 1991).

Lastly, the use of language in SFT is to be empowering. This includes the use of positively framed sentence structure and the deflection away from problem focused conversation. The follow-up questions asked by the therapist consciously emphasize and frequently use the word "different". "What will be different?" "Who will first notice that something is different?" The use of differences is designed to underscore for the client that they must do something different in order for change to occur. This is hypothesized to instill in the client an active role. The client's perception of their actions suggests that responsibility be taken for their future, and motivates the client towards change (de Shazer, 1991). SFT strongly advocates for the therapist to work at the client's pace. To stay focused on this task it is suggested to listen carefully to the client, to use their words to ask the questions, and when uncertain how to proceed to go back to the client's last point of focus.

Relationship Questioning

Relationship questioning is used throughout the sessions whether the client is being seen individually or as a family. These questions follow a similar format by asking the client how other family members would perceive the changes. For example, "What would your husband notice that is different when the miracle has happened ?" "How hopeful

is your wife that things will change?" Relationship questioning is used to enhance the clients' perception of their reality. Depth to the client's story is achieved through the introduction of the significant players' reactions to the miracle and exceptions at hand. This form of questioning negates the need for family agreement on the problem. As the therapist focuses on each family member's miracle, the all too often pattern of blaming is avoided. Common goals and solutions are seen to emerge. As the number of possibilities increase, the chance that things will actually change increases. Relationship questioning allows the therapist to gain greater understanding as to who did what, and to help change the pattern of the problem so that it does not reoccur, even if the conditions for repeating it are in place.

Client-Therapist Relationship

The therapist's task of identifying the "type" of client-therapist relationship was outlined in *Clues*: *Investigating Solutions in Brief Therapy* (de Shazer, 1988). The significance of the relationship is used as a guideline to help choose the intervention that would best fit for the client. Berg and Miller (1992a) used the client-therapist relationship to measure the amount of motivation for change in "problem drinkers". The three general types of client-therapist relationships are described as the visitor, customer, and complainant. The type of relationship is not static but is redefined as the client-therapist relationship evolves (Berg & Miller,

1991; de Shazer, 1988). The client's description of the problem and the responses given to the miracle question and follow-up questions, are used to determine the client-therapist relationship (Berg & Miller, 1991). If the client indicates that he or she has a problem and is motivated to change, the intervention task is a "doing" task. This type of client is viewed as a customer by the therapist. If the client is aware of the existence of a problem, but feels that they are not the cause, the client is viewed as a complainant. The intervention is an observational task, as a complainant has keen observational skills that can be used in a positive manner. If the therapist concludes that the client does not see a need or is not motivated to change, they are considered a visitor. This type of client is not given a task, but is invited to return. Within the context of a family, different family members can have differing categories of client-therapist relationships (Berg & Miller, 1991).

Scaling Questions

Scaling questions are questions that attempt to put a measurable value to subjective and, at times, vague concepts. They are often worded in the following fashion: "On a scale of one to ten, with ten being the most confident that things will change, and one being not very confident at all that things will change, where are you today?" Quantifying these concepts makes them more concrete and workable. SFT concentrates on (a) how confident or hopeful the client is towards change, (b) how

hard they are willing to work to make change happen, and (c) how they see their movement towards change. This assists the client and the therapist in measuring therapy progress. As discussed earlier, it also helps the therapist to determine the type of client-therapist relationship. In therapy, scaling questions are used to identify the solutions and steps needed for change. As an example, the client may identify that they are a four on the scale of hopefulness. The therapist can explore this further by asking "What will it take for you to get to a five ?"

Use of Compliments

The therapist assumes an active role in listening to the client. Verbal and behavioral responses by the therapist are given to exceptions or solutions to the problem that are voiced by the client. This active complimenting of the client throughout the sessions both focuses on and accentuates solution focused behavior and thinking. It reinforces to the client that what they are doing is right for them. It enhances the message that the therapist sees things similar to the client. It also supports the client's actions (de Shazer et al., 1986). This supportive client-therapist relationship is believed to create a greater openness on the part of the client towards the task intervention. To capitalize on this, compliments are given as part of the team message at the close of the session, prior to the delivery of the task. It is argued that the delivery of the message after the break increases the power of the message. Not only is the team

impressed at how well the client has done, the team needs time to formulate the best plan for the client. Thus the client is empowered with feelings of importance, and is more likely to be receptive to the message (de Shazer, 1985; de Shazer et al., 1986).

After the First Session and Termination

Kral and Kowalski (1989) stressed that once change has begun, the task of the therapist shifts towards encouraging the client to "keep it up", and to do "more of the same". They described six approaches that they found useful for building and maintaining the changes made by the client.

1. Described as "cheerleading", positive reinforcement was given to the areas of change. Kral and Kowalski "bet" with the client whether the desired change would continue.

2. They used "positive blame" by blaming the occurrence of an exception upon another, not the client. This was anticipated to emphasize the interactional nature of one's behavior impacting upon another's in a positive fashion.

3. They identified the "new context" for the client by outlining the factors that needed to be present for the desired behavior to continue.

4. The "prediction task" was given to the client to predict when a "good day" or "bad day" would happen. This task was assigned when a pattern of random exceptions has been identified. By having the client

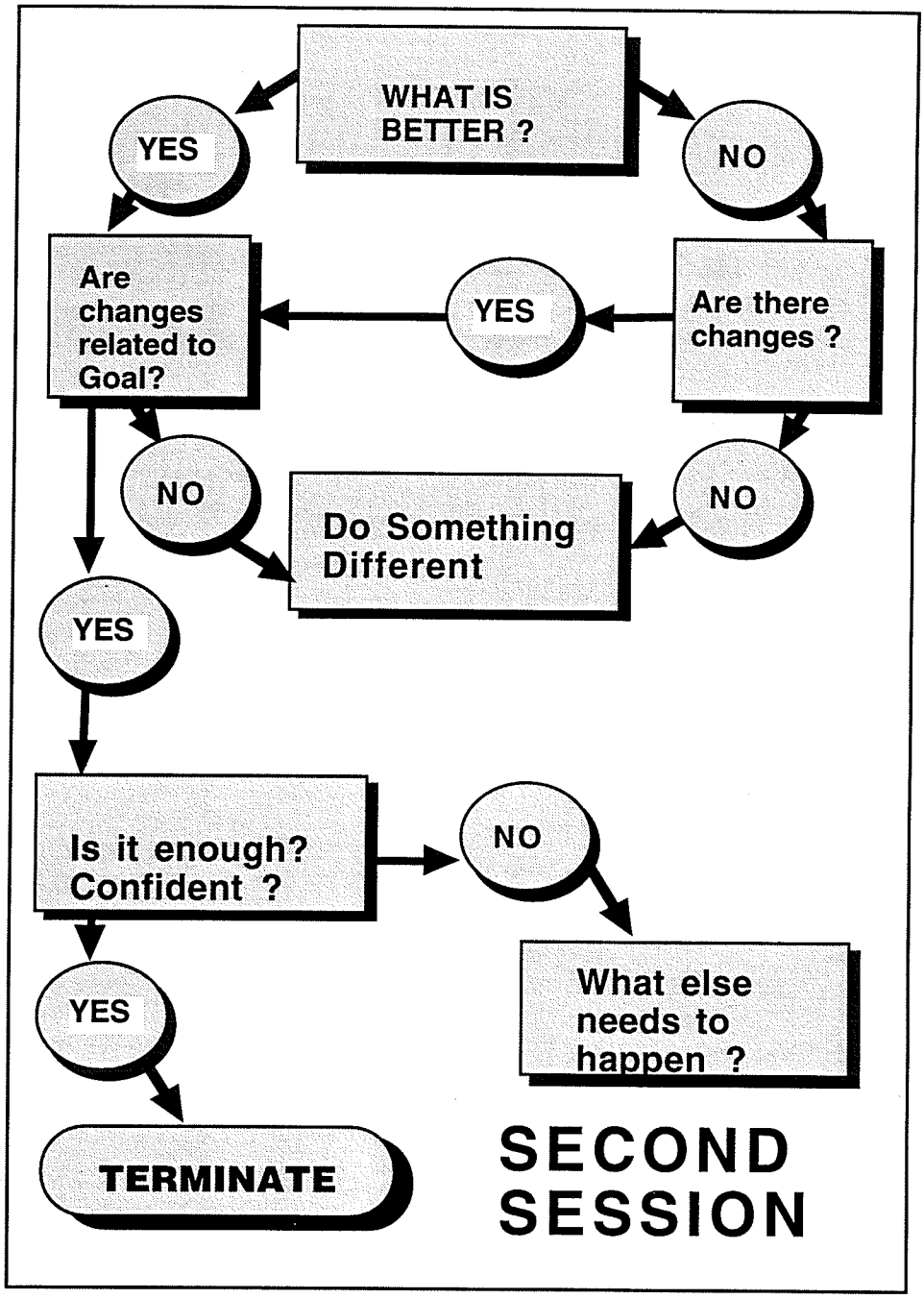
predict what kind of day he or she would have, they can then note what had occurred that made their predictions either correct or incorrect.

5. "Flagging the mine", was when the therapist had the client identify signals that could result in the "old" pattern reoccurring.

Subsequent sessions of SFT follow a simple format (see figure 3). The initial question is stated: "Before we get started we want to know what have you noticed is better?" The therapist responds accordingly to the client's successes. If the client reports that things are better, then the therapist needs to determine if change has occurred. If change has not been happening, the task given is to do something differently. If the client recognizes change, and if the change is related to the goal, the therapist would question if that change is "enough"? If it is not, then "What else needs to happen?" If the changes are sufficient, then the therapy can be terminated. Scaling questions as to how confident the client is that change can be maintained, or what is needed to have the change continue are incorporated to reinforce the client's readiness. Termination is considered to be a mutual agreement between the therapist and the client (de Shazer, 1991).

FIGURE 3. Second Session Format

Adapted from Principles of Intervention Design (Berg and Miller, 1991) this figure illustrates the SFT response driven second session format.



Discussion

This chapter has provided to the reader only the salient aspects of the solution focused model. SFT has been used as a team approach. The process observation of therapy sessions by de Shazer and his colleagues has led to the refined format of SFT. Typically the team is situated behind a two-way mirror. They not only observe the therapy in progress, they supply both solicited and unsolicited consultation to the therapist. The miracle question appears to be the trade mark and focal point of SFT. The highly structured format, the use of standardized process interventions, and the boasts of problem resolution following one session (de Shazer, 1991) contributes to the appeal of SFT. It is this "quick fix" therapy approach that warrants further discussion.

De Shazer (1991) contended that change was promoted when the meaning or label of the problem was renegotiated through the use of "language games" and was accomplished by the client reframing the original problem. De Shazer (1991) stated that:

> The change or transformation that follows the redistribution or inversion of concept and criteria, the reversal of hierarchy, and the solution-focused language game needs to be held in place, to be tacked down within the therapeutic conversation for pragmatic and therapeutic purposes.

Although not explicitly stated, SFT appears to be analogous to the model of constructivist theory and the "co-created meanings" between the therapist and client. The "core" of constructivism follows the Kantian model of knowledge. Knowledge was argued to be an "invention" of an active being interacting with its environment (Efran, Lukens & Lukens, 1988). The emphasis is on language as the "essential" link to social community. It is value laden, and "is not just an action or an event - it is a framework of activity and interpretation, made possible by the shared language system in which we all operate" (Efran, Lukens & Lukens; 1988). Therefore, to apply a constructivist perspective to therapy involves the invention, reshaping and development of new understandings of life experience.

Minuchin in *The Seductions of Constructivism* (1991), challenged the constructivism theory by suggesting that (a) the "expert" position exists covertly, (b) families interact with more than language, and (c) there exists a reality that extends beyond the client. Minuchin suggested that mental health professionals have traditionally been sensitive to their client's reality, and the constructivist attempts to avoid the role of "expert in a politically correct society, in fact make the power differential invisible by denying its existence" (Minuchin, 1991). The "expert" position that SFT and de Shazer repudiates is in the student's opinion one of the driving mechanisms of the SFT model. Expressed, or hidden as

"techniques" one could argue that this covert power is manifest in "the solution focused language game", "inversion of concept" and the use of "compliments" to increase client compliance. Such techniques can be viewed as calculated manipulations that are sanctioned by de Shazer. The dynamics of these techniques appear to depend on the client being uninformed. Were de Shazer to be forthright with the client about the means to the ends, one could assume that the power of SFT would be greatly diminished.

Minuchin most strongly emphasized the injustices of the world through the case example of Central America, with its realities of disease, poverty, hunger, and political terrorism. Minuchin (1991) wrote:

> It is hard to believe that a therapy based on the theory that a family organism is a self-determining, organizationally closed unit would suit families coping with hunger, drug addiction, AIDS, physical abuse, bigotry, racism, sexism or political violence.

Minuchin further indicated that the development of family therapy has historically been capable of balancing the need to be sensitive to the client's perceptions and the "real world". He suggested that the strong emphasis on language, "undermines one of the historic advantages of family therapy - it's pioneering use of experiential and action oriented techniques".

The tool of change for SFT is language, and "language games" that alter the client's depiction of their reality. The student concurs with Minuchin that to devalue or deny these realities existing outside the family system commits injustice. The recognition of a social structure that oppressed women provided the impetus for the feminist movement. To suggest that the family has the ability or capacity to control untoward events, can be construed as blaming the victim. There would be no need to change the inequities of the greater social system only the need to change perceptions of it. To take the argument to the extreme, if one were to deny the reality of the outside world, one would be forced to validate a psychotic process that would be unique to each individual. There would be no objective "truth", as life would hold no perspective, rather all would be relative to only internal cues. This perspective then nullifies the use of language as a social construct, and eradicates its ability to be an effective tool of change.

The brevity and superficial sentiment of de Shazer's SFT model challenges the student's clinical practice of interpretive therapy established in the development of the "therapeutic relationship". The student receives de Shazer's claim of one session "cure" and "no need to know the problem" with skepticism. In his book *Putting Differences to Work* (1991), de Shazer suggested that "whether by design or default therapists can expect one (1) to be the modal number of sessions throughout their career". To lend support to this claim that one session

can be "sufficient" for any model of therapy, de Shazer pointed to Jone's biographical account of Freud having "cured Gustav's Mahler's sexual impotence during a single long walk" (de Shazer, 1991). In essence what de Shazer had suggested to the reader was that one session walk was equivalent to one session, and dismissed the contextual components or the "realities" that existed beyond that one encounter. The contextual relativisms of this infamous meeting had been aptly expressed by John L. Kuehn in *Encounter at Leyden: Gustav Mahler consults Sigmund Freud* (1965). At the turn of the century Vienna's artistic and esoteric social circles were frequently shared. Mahler's "neurotic" behavior was well known. Mahler had contacted Freud on several occasions. The four-hour single session was not an isolated incident. It was the culmination of a series of events and influences. Jones is quoted by Kuehn as suggesting that a one session cure was "impossibly quaint and naive". Freud had reported that "he had never met one who understood the principles of analysis so quickly. Thus Freud in his own intuitive genius recognized he was in the presence of an extraordinary personality" (Kuehn, 1965). De Shazer does not address the existence of these and other factors as having made a contributing impact to treatment success. It appears contradictory that one who holds a constructivist view of reality, such as de Shazer, can be so dogmatic in informing others of theirs.

One may suggest, as did O'Hanlon and Weiner-Davis (1989), that the clinical practice of brief therapy differs from long-term therapy in having a philosophy that does not include the therapeutic relationship. Steve de Shazer described the client-therapist relationship in utilitarian terms and as determined by the client's responses to questions (de Shazer, 1988). Stephen Proskauer (1969) in his article *Some Technical Issues in a Time-Limited Psychotherapy with Children*, outlined three phases to his brief therapy approaches that averaged 13 sessions. Phase one was the forming of the relationship, and the defining of a focus for treatment. Phase two took the formation of the positive relationship as helping to facilitate change in a limited area of the child's functioning. Phase three was the termination. What Proskauer outlined as the "key" to his brief therapy, was the child's "capability of rapidly developing a positive working relationship with the therapist" in order for sufficient trust to be viewed as "growth not abandonment" (1969). De Shazer's impersonal approach was further emphasized by SFT's highly structured format that was correct response driven. De Shazer suggested that the development of computer programs to follow the format would be effective therapy. This impersonal approach by de Shazer could perhaps have contributed to his "reality" of his modal number of sessions being one.

What perplexes the student are the apparent contradictions

between de Shazer's clinical philosophy and that of his colleagues. De Shazer appears to take pride in his "skeleton key" metaphor, claiming to have the key to fit all locks. Although conceptually SFT was designed for use in every client situation regardless of presenting problems (de Shazer, 1991; de Shazer et al., 1986), modifications to the format were suggested by Scott and Hopwood to appropriately respond to the client in crisis (personal communication, 1992). Modifying SFT techniques to make them population specific, Berg and Miller describe their "solution-focused approach" with substance abusers (Berg & Miller, 1992b) and Asian American Families (Berg & Miller 1992a).

In summary, SFT as practiced by de Shazer, is a brief therapy model that has a structured format, utilizes techniques that emphasize a positive focus and has a philosophical basis that offers a constructivist view of reality. The student's key criticisms of this model include the devaluing of the client as a person in the guise of correct response driven format and the manipulative quality of the client-therapist relationship. De Shazer exercises power covertly by the denial of its existence and in his emphatic and dogmatic presentation. However, the student did feel the model's appealing pull. As with life experiences, the development and the maintenance of therapeutic relationships are difficult and time consuming. An effective therapeutic model able to offer more for the client (brevity, user friendliness) with less personal investment by the

therapist could be construed as ideal. The student was intrigued at better understanding the SFT model and exploring it's clinical application at FSI.

CHAPTER 4

THE PROCESS OF FORMATIVE EVALUATION

This chapter outlines the student's experiences as a formative evaluator at FSI. It describes the practicum site and organizational relationships. It summarizes the months of discussion, and details the goals established by the agency that functioned as the parameters for the student. The student has highlighted the salient concerns and decisions that shaped the process of the development of the examination of SFT and the research design.

Practicum Site and Clientele

This practicum was conducted at Family Services of Winnipeg Inc. (FSI), a community based agency that serves the urban population of Winnipeg. One of the primary goals of the agency is to provide family-focused services which respond to identified community needs (55th Annual Report 1991-1992). During the 1991 fiscal year there were over 3,000 requests for counseling services (55th Annual Report 1991-1992). Almost half of the clientele who utilized FSI counseling services were in the lower income bracket, with 54% of the net family income under $10,799 (see table 1).

Table 1.

Family Income of those receiving Counseling Services at FSI.

Family Income	Percentage of Clients per Year		
	1987	1990	1991
under $7,200	39.4%	35.3%	39.7%
$7,200 - $10,799	14.6%	14.3%	14.2%
$10,800 - $14,399	13.5%	18.2%	15.9%
$14,400 - $17,999	12.1%	13.4%	12.0%
$18,000 - $21,599	8.1%	8.2%	7.4%
$21,600 - $25,199	4.2%	6.4%	5.2%
$25,200 - $28,799	4.8%	.89%	2.7%
over $29,000	3.3%	3.4%	2.9%

Note. figures have been rounded to the nearest decimal

Organizational Relationships

The staff members of the counseling program were Bachelor and Master's prepared social workers or those from related disciplines (see table 2). They provided both assessment and treatment for those who sought services at FSI. There were two teams of staff at FSI who had adopted SFT as part of their treatment repertoire. The two teams shared a team leader, who was involved with the administration of the clinical services. The two teams were differentiated from the other clinicians at FSI and will be referred to as the "research group". The research group totaled seven therapists. The agency had invested in two years training of SFT to provide "clearer communication and potentially more cost effective services" (55th Annual Report 1991-92).

Table 2.

Educational Achievements of the Research Group at FSI

EDUCATIONAL ACHIEVEMENTS OF THERAPISTS
R.N., M.ED. EDUCATIONAL PSYCHOLOGY
B.S.W.
M.S.W.
M.S.W.
M.S.W.
B.S.W.
M.ED., EDUCATIONAL PSYCHOLOGY

The research group considered themselves to be in the "learning phase" of SFT. They were interested in researching the treatment's effectiveness. The therapists acquired their theoretical and practical applications of SFT through the attendance of workshops, extensive reading and through peer supervision. Although the two teams utilized SFT, team members had their own theoretical orientation. The agency appeared to have accepted an eclectic treatment approach. The SFT treatment intervention appeared to be the agency's first attempt at providing treatment consistency across therapists.

Creating the Research Parameters

The first general meeting at FSI attended by the student was held in the summer of 1991. Present were the student's advisor, the agency's executive director and the seven therapists who practiced SFT. In the role of formative evaluator, the student's agenda was twofold - firstly, to acquire information pertaining to the agency that included philosophy, mandate and program design and secondly, to introduce the rudimentary research proposal.

The student ascertained that the two teams worked with individuals, couples and families who were viewed behind the one-way mirror. The average contact with families was described as 4 -5 sessions, couples 6 -8 sessions, and individuals 10 -12 sessions. The

counseling program had a three month waiting list. Intake calls were responded to by staff members and students of social work. The intake calls were presented to the intake coordinator. The coordinator would then distribute the cases to the therapists. At the point of therapist and client contact, the decision regarding treatment would be agreed upon. Each therapist was responsible for the management of their own caseload including termination. When a file was closed, a Client Satisfaction Questionnaire was mailed.

The second item on the agenda was the introduction of the research proposal to the agency. It was conceptualized into a two-phased project. Loosely framed, this project would include a pre-test, post-test, and follow-up piece. The research design projected 75 - 100 cases to be seen during a six to eight month period. The student and her advisor suggested to the team a measurement that would evaluate general functioning. Case selection would be purposeful, not random, and would be decided by either composition (individual, family, couple) or by problem. Discussion included the introduction of qualitative data gathering that explored the client's feelings about treatment, what they felt was most helpful, and how was this compared to the therapist's perceptions of treatment. Phase Two of the project would attend to the development of a more rigorous research design.

At the end of this first meeting it was formally agreed that the research group was willing to participate in and be involved in the collection of data. It was identified that the research project needed a guide of assumptions as to the goals for the research, and what the therapists hoped to accomplish. The team viewed the research as a fledgling project that would conceivably evaluate the effectiveness of their treatment intervention.

Over the course of the next four to five months, the student met with her student advisors, the executive director, the clinical coordinator, and the research groups, in whole or in part. The original research proposal took on new shapes and dimensions as the needs of the therapists and program goals became more clearly identified.

Research Goals

The three primary goals identified by the research group were: (a) to provide effective counseling intervention, (b) to enhance knowledge and proficiency in the utilization of SFT, and (c) to continue individual professional growth through research and evaluation. These goals were further operationalized by the student and described with their related concepts as follows:

Goal 1. -- To identify the degree and direction of change using the constructs of coping as measured by depression, self-mastery, economic stress and family functioning.

Theoretical Link of Measurement and Change

The examination of treatment effectiveness attempts to address the value of a particular intervention with a specific client population by "linking" action and outcome (Lind & O'Brian, 1971). It was imperative for the student to have measurements that would link the FSI client population and the SFT treatment intervention.

Pearlin and Schooler identified chronic and acute stress that is interactive and cumulative arising from our social structure such as role strain, and life events (Pearlin, 1989; Pearlin & Schooler, 1978; Pearlin, Lieberman, Menaghan & Mullan, 1981). Continued source of stress creates a diminished sense of self including a decreased ability to master one's environment. Coping was conceptualized as "any response to external life strains that serve to prevent, avoid, or control emotional distress" (Pearlin & Schooler, 1978). The function of coping behavior could be viewed as the individual containing their emotional responses within manageable boundaries and by "perceptually controlling the meaning of the experience in a manner that neutralizes it's problematic character" (Pearlin et al., 1981). The theory of SFT that identified agents

of change in the "creation of new meaning" through a variety of techniques appeared to be a good fit with the Pearlin construct. The student's working hypothesis was that the therapist's focus on the solution instead of the problem would influence the client's perceptions. It was assumed that increased coping would increase the positive sense of self and self-mastery. It appeared to follow that should the individual enhance their ability to cope, change would be reflected in these areas.

Goal 2. -- The second goal was the development of a research design to assess the effectiveness of the SFT.

A heterogeneous population posed difficulty in measurement selection. The measurements had to be sensitive to change in order to address the needs of evaluating a brief therapy model. Thus global personality measures would not be adequate, and more specific and subjective measures were required (Kazdin & Wilson, 1978). As this was an exploratory research project, it was the student's intent to provide a variety of measurement instruments.

Stress and Coping Questionnaire

In consultation with Professor Pearlin, a 36 item self-report questionnaire was adapted by the student (see appendix D).

Pearlin and colleagues had identified over 144 items related to stress and coping that were derived from prior research in which 2300 people had been interviewed. Through a process of step-wise regression, and factor analysis, weighted statements measured role strain, stress and coping in the areas of marriage, parenting, household economics and occupation. Each item indicated a gamma coefficient that was statistically significant with item loadings that ranged from .45 - .79 (Pearlin & Schooler, 1978; Pearlin et al.,1981).

Three sub-scales from the stress process research measuring psychological coping resources were chosen by the student. These questions were modified, and a Likkert scaling format was used to examine the constructs of self-mastery, depression, and economic strain. The score range was from 36 to 144. The lower score was indicative of better functioning. Information as to the internal and external validity of the questionnaire, and standardized scoring was not available to the student. Based on the work by Pearlin and colleagues the items appeared to have good face validity.

Brief Family Assessment Measure

The Brief FAM was included as a pre, post and follow-up measure to supply an added dimension for evaluation (see appendix H).
The Brief FAM, a 14 item self-report, forced Likkert questionnaire was

adapted from the Family Assessment Measure (Skinner, Steinhauer & Santa-Barbara, 1981). Ranging in scores from 14 to 56, the lower scores indicate better functioning. The Brief FAM supplies a standardized measure of family functioning. It provides mean scores for both clinical and "normal" families.

Self -Anchored Scale

A major tenant of SFT is the establishment of goals in the first session. De Shazer wrote that the identification of goals informed both the client and the therapist when therapy should terminate, and what will be present when the original problem was no longer perceived as such (de Shazer, 1991). Goal Attainment Scaling (GAS) developed by Kiresuk and Sherman (1968),"is emerging as one of the most frequently utilized methods of evaluating human service programs" (Choate, Smith, Cardillo, & Thompson, 1981). Calsyn and Davidson (1978) cautioned against the sole use of Goal Attainment Scaling for program evaluation and suggested a "multi-variate assessment strategy" as the GAS shows poor content reliability. GAS allows for the identification of treatment goals specific to the client, identifies the range to which the goals are obtained and supplies comparative data through statistical calculation (Woodward, Santa-Barbra, Levin & Epstein, 1978). Typically Goal Attainment Scaling uses five anchor points from worst anticipated outcome to best expected outcome, with the expected goal being placed

at midpoint between the two extremes. The probable outcomes are expressed in clear behavioral terms. The GAS was originally designed for independent raters to evaluate the client's goal attainment post treatment (Davis, 1973; Kiresuk, 1973). GAS allows for a "two tiered" system of outcome evaluation. It measures individual treatment success, and as a whole provides data for program evaluation (Pietrzak, et al. 1990).

This research design, a standardized question was asked at the initial session, and at the beginning of each subsequent session to measure client movement. The wording of the question was "On a scale of one to ten, where ten is where you want to get to, and one is when you first called the agency, where are you now ?" The benefits were twofold: (a) to assist in the framework of the sessions, and (b) to assess client movement with data that could be quantified. In subsequent sessions the anchored scale was used to establish with the client "where are you now in relation to when you called", indicating a continuous measure of treatment effectiveness based on goal attainment progress. A scaling form was developed by the student to: (a) assist the therapists in collection of the data, (b) to serve as an instrument of treatment consistency, and (c) as a visual prompt to remind the therapists to ask the self-anchored scaling question (see appendix E). At the termination of therapy, the self-anchored scale indicated treatment success on an

individual level and allowed comparison across clients as a measure for the evaluation of the program as a whole.

Follow-up

A SFT follow-up form was devised based on the previous research designs by Weakland et al. (1974), de Shazer (1991) and Kiser (1991), discussed in Chapter 2. The final draft was completed after the research interviews in order to incorporate the therapist's input (see appendix F).

Goal 3. -- To increase the therapist's proficiency in the utilization of SFT through the development of a first session observation form (see appendix A).

The first session observation form was a product of the formative process. It was developed in response to the concerns of providing uniformity of therapy across time and therapists who were at differing stages of comfort and experience in using SFT. The research group decided to focus exclusively on the team approach. The student ascertained from the therapists consensus of the SFT markers that were to be present in the first session. Service delivery of SFT among the therapists and over time would be measured by the objective markers. At another level, the use of quantifiable measures could possibly evaluate the peer supervision intervention. Can this process be evaluated, and if

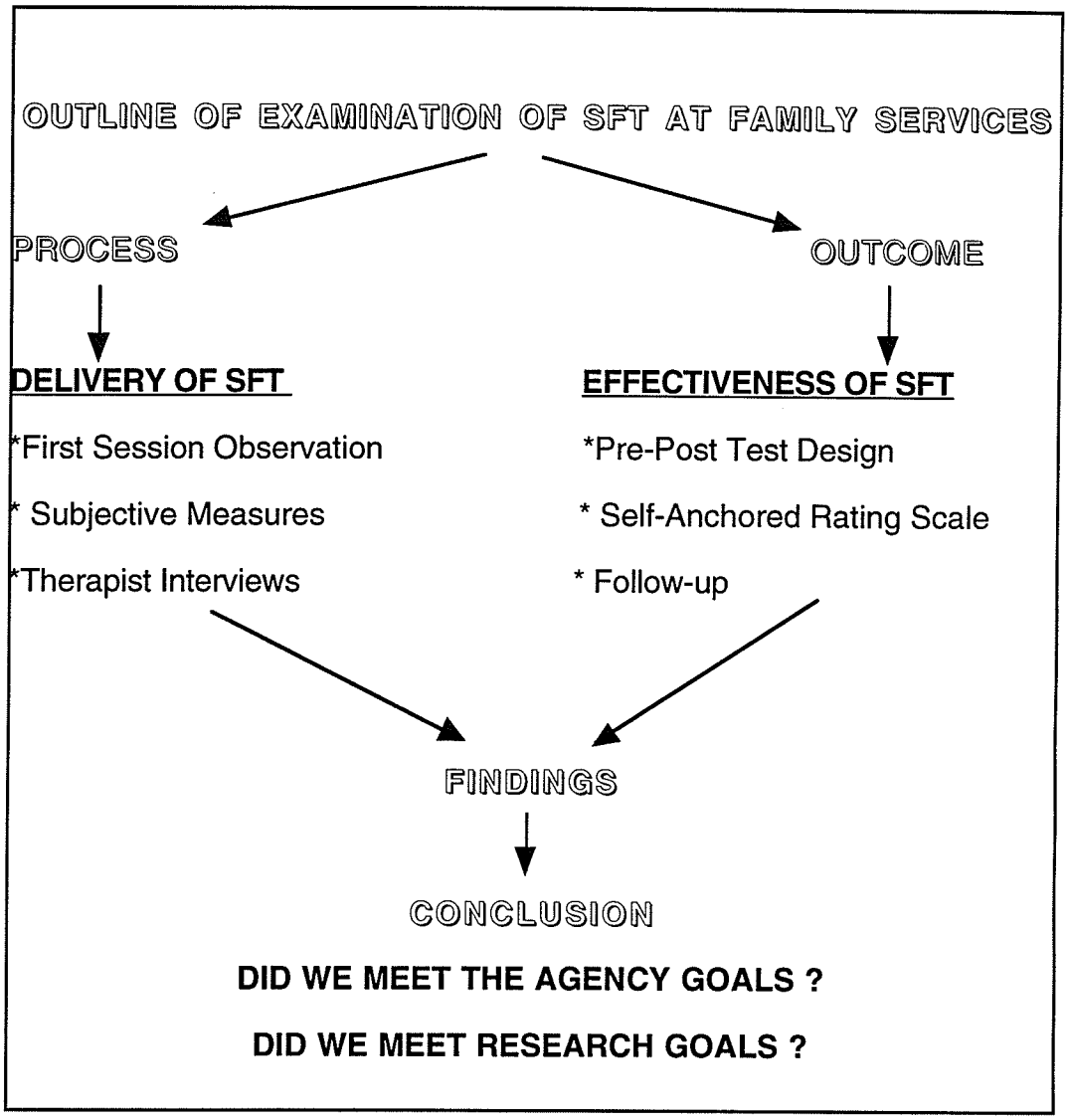
so, how can it be evaluated? Was the delivery of SFT by the therapists enhanced by peer supervision? By supplying a method of gathering quantifiable data the form could potentially be used as an evaluative tool to measure change or progress of that service delivery. This was hoped to enhance the therapists proficiency.

Goal 4. -- To evaluate research success as determined by agency identified goals. Examination parameters were developed that included the agency goals (see figure4).

Goal 5. -- To determine therapists' satisfaction with SFT through the use of semi-structured interviews.

Some therapists voiced subjective discomfort in using SFT compared to the more seasoned SFT therapists. At the heart of the evaluation project was the conundrum "What do the therapists perceive themselves doing, and what are they actually doing ? In response to the underlying philosophical questions of "Are we able to design our values and belief systems in the solution focused model ?" and "What are our common goals ?", the development of an exploratory semi-structured interview was presented (see appendix B). It appeared at that time the therapists' questions were "How does the solution focused model fit for us?" and "What makes sense for us in this model?"

FIGURE 4. **Diagram of the Parameters of the Examination of SFT**



Implementation Phase

The student's role as a formative evaluator commenced with the initial contact with FSI in the summer of 1991, and continued till December of 1992. The semi-structured interviews commenced in December of 1991. The student's intention was to interview the entire research group before the start of the project, however that was not possible. The first interviews were completed in February 1992. The second interviews were completed in October 1992. Meetings with the teams were held on an ad hoc basis in response to concerns as well as the reporting on the progress of the project.

The culmination of the team's input was presented in the format of evaluation research (see appendix C). The research project that measured the SFT intervention formally commenced at the beginning of January. Research files were prepared for the therapists that included the consent to participate in a research study (see appendix G), the pre and post-test questionnaires, and the first session observation form. A log book was established. Changes that emerged during the review meetings were relayed to the team members by the clinical coordinator.

After the first month the therapists had indicated that they were encountering difficulty in obtaining clients that would agree to participate in the research. The generation of research numbers was a concern as

the therapists were finding approximately a 30% no show or cancellation rate. This was slightly higher than the agency average that was estimated at being 25%. The result was a small sample size that was influenced by difficulties in scheduling, screening and attendance.

Interim Evaluation

After five months the preliminary results of the first session observation forms were presented. The objective measures of proficiency and level of comfort were consistent with the subjective responses from the team members. The development of the first session observation form did provide consistent use of the first session format of SFT. What became apparent was the lack of desire for most therapists to adhere to the formalized first session structure. The research group response was of interest as well as confusion as to what the project had accomplished, and what was the measure of its success.

Discussion on Process

The incorporation of agency mandate, clinical practice and research posed many challenges. The initial concerns focused on research design, comparison group, and inclusion criteria. As the research progressed, difficulties in the area of communication, generation of research subjects and participation in a research project emerged. The initial research proposal that broadly looked at the

effectiveness of SFT, was becoming less of a focus. What appeared to be occurring was the research group becoming less concerned with rigorous experimental design, and more concerned with the impact of research on their clinical practice.

What emerged from the formative process was a three-tiered exploratory project that addressed the issues of service delivery, the effectiveness of the intervention, and the subjective satisfaction with the intervention.

Comparison Group

The student was requested to explore the possibility of implementing and coordinating a research design that included a comparison group. The research group decided that it was not logistically feasible to use a waiting list control group. Practical and financial concerns arose as to how successful it would be to mail out questionnaires to those who call in distress. A suggestion was posed to obtain a comparison population from the clients who were being treated by the therapists who were not involved in the research project. This suggestion was not supported. Following the study by Adams, Piercy and Jurich (1991), the student suggested that control groups be generated from the therapists' own case loads. This would entail the therapists being responsible for dividing their caseloads into SFT and

non-SFT clients. This was not supported, as concern was raised to the difficulty in transforming from one therapeutic approach to another resulting in treatment contamination. The decision was made to incorporate a control group design in later research. Should the first phase of the research project prove successful in the therapists' consistent use of SFT, their ability to transition from one treatment modality to another with less contamination was viewed as possible.

Inclusion Criteria

The practical issues such as intake process, maximum number of sessions, client population and exclusion criteria were discussed at length. The research team identified an average number of eight sessions for each case. They estimated that the seven therapists generated approximately ten cases a week. They expressed concern that should the research be too exclusive in client population, the project could be faced with time frame difficulties to obtain data that would be statistically significant. It was the student's assumption that most clients would be seen in the context of families. This would allow for individual cases to be made from one client base and would generate greater research numbers. It was the opinion of the student that this theoretical construct was congruent with the de Shazer treatment model. De Shazer emphasized that individuals in the family system did not need to share the same goals.

Consensus was that those who self -referred would be more motivated towards change. Exclusion criteria that was developed included families receiving mandated intervention from Child and Family Services and those who required long-term therapy, such as incest survivors. Those who were mandated were not voluntarily seeking treatment, and thus should not be exposed to a research project. Those seeking long-term intervention were not considered to be appropriate candidates for the brief model. Clients being seen through Employee Assistance Programs (EAP) would not be included in the research. Consensus was not to include contracted work. Debate surrounded substance abuse and domestic violence. As approximately 25% of the clients who have been seen through the counseling services have "some form of family violence" (55th Annual Report, 1992), these problems were not exclusionary criteria, but rather representative of the client population.

The research team recommended that clients who attended more than two sessions would be appropriate for the study. This would allow for comparison data. Following the theory of SFT that identified significant movement towards client goals after one session, this was felt to be a reasonable inclusion criteria.

Generation of research subjects

The original estimate of 75 -100 cases was optimistic. The group agreed upon a more conservative estimate of 30 cases. Concern arose regarding clients who agreed to the team approach, but refused to participate in the research study. To delay the client in receiving services was not ethically appropriate, nor was it appropriate to present the team approach as exclusively research. That would alter the services that were provided by the agency. It was decided that concomitant with the research project, the team would continue to see those clients who did not wish to participate in the study. It was the research group opinion that this would impact upon the number of research subjects

Communication

From the student's experience, what became apparent was that the formative process required an active mechanism for communicating to all of the research members. The problem of communication was made even more difficult due to the student's limited availability. Further difficulties with evaluation research will be discussed in chapter 7.

CHAPTER 5

EXAMINATION OF SERVICE DELIVERY

This chapter discusses the examination of service delivery. This included adherence to the SFT first session model, treatment consistency across therapists, therapist subjective and objective comfort with the SFT, and the obtainment of process and outcome research goals.

Procedure

The first sessions were video-taped and rated by the peer supervision group and the student. The therapists were evaluated as to their adherence to the SFT first session format. Objective and subjective data was collected to ascertain the therapists' level of comfort in using SFT.

The semi-structured interview format allowed the student to gather the therapists' subjective responses to their impressions of SFT, and their theoretical understanding of change. This interview was also used as a forum for evaluating this student's involvement with the agency in the role of formative evaluator.

Instrumentation.

The therapist's first session observation form was created with the research team. It identified the salient components of the first session.

Each component had a rating scale that was to be completed by the team members observing the first session, and the student during video-tape observation.

The second component of this first session observation form invited the therapists to share their subjective feelings about what they had experienced, as well as to identify areas in which they felt uncomfortable.

The semi-structured interviews were conducted prior to the start of the intervention research, as well as at the conclusion. Therapists were asked self-anchored scaling questions that addressed their subjective comfort and proficiency in using the SFT intervention. The interviews allowed the therapists to expand upon or identify feelings or ideas that had altered over the course of the project. Data gathered included the therapists' experiences of being involved in a formative research project.

Findings and Discussion of Service Delivery

First Session Observation

Of the nine first sessions, seven were viewed (two tapes were not available due to mechanical malfunction). The therapists were rated on a scale of 1 to 4 for inclusion of the first session criteria, with (1)

indicating not at all, (2) indicating partially complete, (3) indicating almost complete, and (4) indicating completely (see table 3).

Statement of the problem "What brings you in here today?"

The research group ratings ranged from 2 to 4 with the average being 3.58. In this area the research group identified two occasions in which they felt uncomfortable in using the question. In one case the therapist felt that they needed to stay with the client's "story telling", but felt hindered to do this because of the research format. The other identified an occasion when this question was not successful, due to the client's difficulty in staying focused and making exact statements.

Miracle question

The initial introductions and the exploration of the problems continued for approximately 18 minutes before the miracle question was asked. On two occasions the team called the therapist to initiate the miracle question. The therapists ratings ranged from 2.5 to 4 on the scale, with the average being 3.4. The two occasions when the therapists were identified as having difficulty in asking the miracle question arose from the client's extreme distress. In one case the client had long standing difficulties with health, and would digress with much circumstantiality, making it difficult for her to respond to the question. In the second case the client had difficulty due to recent turmoil in the home.

Statement of exceptions

Seeking exceptions to the rule were not consistently pursued by the therapists as were the more defined aspects of the first session. The ratings ranged from 1 to 3.6 with the average rating being 2.8. In reviewing the tapes one therapist did not seek exceptions, although the client did provide opportunities for exploration. On one occasion the research group instructed the therapist to focus on the exceptions. When the therapist did search for the exceptions it was done successfully.

Scaling questions

Most clients were asked the three scaling questions that were identified as "from the time you called", hopeful/confident for change and willingness for change. The therapist ratings ranged from 2 to 4, with the modal number being 4. In one instance the team observed that the therapist had difficulty in asking the scaling questions due to the client's perceived lack of comprehension. Of the clients who were asked the scaling questions, all identified an improvement since the initiation of their contact with FSI.

Compliments

The use of compliments during the first session was consistent. The averaged rating was 3.3. One therapist noted that in a particular

case the use of compliments was limited due to the clients difficulty in accepting them.

Assigned task

The assignment of a task at the end of the sessions was not used consistently by the research team, with ratings ranging from 1 to 4. On three occasions the team felt it would be inappropriate to assign a task. In one of these instances the team suggested a psychiatric evaluation, in the other a meeting with the client's partner.

Level of comfort

Most therapists appeared to have a high level of comfort in using SFT indicating an average rating of 3.45. One therapist did not appear comfortable in using the SFT model. However, this was consistent with the amount of distress the client was experiencing. Factors such as the client's age, language barrier, cultural difference, and level of "depression" appeared to contribute to the therapist's difficulty in conforming to the SFT format.

Table 3.

Mean Scores of Therapist First Session Observation Form

CRITERIA	MEAN SCORES OF THERAPIST FORMS OF 9 FIRST SESSION OBSERVATIONS								
Statement of problem	3.5	3.3	3.3	2	3.3	4	4	3.6	3.5
Miracle Question	3.5	3.6	2.6	2.5	3.3	4	4	3.6	3.5
Minutes till MQ Asked	6	18	16	15	25	n/s	28	17	n/s
Statement of Exceptions	3	3.6	3	1.5	2.5	4	1	3.3	3.5
Scaling Questions	4	4	4	2	3.3	4	3	4	3.5
Use of Compliments	3	3.6	3.6	2	2.6	4	3.3	4	4
Assigned Task	3	4	3	1	3.3	4	1	4	1.5
Level of Comfort	4	3.6	3	2	3	4	4	4	3.5

Note. n/s = no score

First Session Subjective Responses

The subjective level of comfort identified by the therapists after the first session was fairly consistent with the objective ratings. The exception was one therapist who subjectively indicated a low level of comfort, while the observers rated the perceived level of comfort as high. Comments made by the therapists to help explain this discrepancy appeared to be related to the level of comfort in using the miracle question. Discomfort was identified by the therapists when they felt the client needed to talk, and therefore did not wish to conform to the rigid format. One therapist questioned if the format adversely influenced the client's ability to engage with the therapist, and concluded in the end that the format supplied a "frame" to the session, noting that a connection was felt between the client and therapist. Two therapists noted that it was difficult to focus on the positive when the client presented as being depressed. One therapist who felt uncomfortable with the first session indicated how difficult it was to have a client participate in a research project when they were overtly distressed.

Therapist Interviews

The semi-structured interview format used by the student was found to be a useful tool for information gathering. It allowed a freedom to explore with the therapists their thoughts and feelings, including a sensitivity to change. Six of the seven therapists were

interviewed twice and the seventh only completed one interview due to scheduling difficulties. The interviews were from 20 minutes to one hour in duration (dependent upon how bounteous was the therapist). The average length of time was 30 minutes. The responses were hand transcribed. This was adequate but not preferable. However, despite the omissions and the natural misinterpretations that occur from such an imprecise method of recording, it is the opinion of the student that the ideas, opinions and feelings of the therapists were reasonably portrayed.

The analysis of qualitative data has been historically viewed as more of an art than a science. Its purpose is to identify common themes and patterns. The program used to prepare the qualitative data gathered by the student was *THE ETHNOGRAPH A Program for the Computer Assisted Analysis of Text Based Data* (1988). As the name suggests this program provides assistance in the organization of data into conceptual categories. The semi-structured format of the interviews provided the original categorization of data as delineated by the questions. The original text was transcribed combining the two interviews, and formatted for the ethnograph program. The program then numbered each line, which enabled this student to "map" and "code" themes that were seen to emerge. The final codes that were entered for analysis reflected the:

1. THERAP KNB - therapists knowledge base of solution focused and other treatment modalities that were raised in the interview.

2. THERP EXP - Therapists experience with SFT and other therapies that were raised during the interviews.

3. ENNS APP - The method of intervention used by George Enns as understood by the therapists.

4. SFT APP - SFT as understood by the therapists.

5.CLIN PRAC - Style, theory and comments pertaining to the therapists clinical practice or identified as being important to clinical practice.

6. CLTH REL -The client/therapist relationship.

In analyzing the responses there emerged a definite flavor to the therapists experiences with SFT. It underscored the students initial concerns of client-therapist relationship. The ethnograph program enabled this student to explore this in a more refined methodology.

Therapist knowledge base -- The therapists individually and collectively had a wide and impressive knowledge base. The backgrounds were varied, ranging from what they identified as cognitive behavioral, structural, to Ericksonian theory. Some incorporated a Feminist philosophy. However, all discussed the adaptation of their clinical practices to a solution focused approach. The primary courses of learning the SFT had been through workshop attendance, individual readings, as well as through peer group supervision. The level of

experience in using SFT ranged from the "exploration and learning" stage with slightly over one to two years of experience, to one therapist who had been incorporating SFT into her practice for over five years .

All therapists agreed that SFT promoted change. However, the mechanisms for change were less clearly defined. Most therapists articulated their belief that individuals have the strengths and resources within to solve their problems. The underlying assumption was that the individual naturally moves towards health as part of his/her growth process. The focus on the positive was viewed as a key factor in the promotion of change. In one instance this was understood as promoting the client's self-esteem, in another, as possible biochemical responses to the verbalizations of success, and in another as the result of the increase in options available to the client. There existed doubt as to the effectiveness of SFT with ingrained attitudes or beliefs. The impact of hopefulness was believed to be experienced by both the client and the therapist. For some therapists, SFT provided hope and strength by avoiding the "muck" and "heavy plodding" experienced with the problem focused models.

The client-therapist relationship -- The importance of the client-therapist relationship as influencing change was identified as a significant factor. This included a respectful, therapeutic relationship that

was safe, and built upon trust. The power of the relationship was also clearly indicated for those clients that had been identified as "needy" and who painfully lacked significant others in their lives. The healing process was believed to be the relationship between the client and the therapist for those isolated individuals. These identified agents of change appeared to represent a theoretical base that was value laden. The nature of client-therapist relationship that included sensitivity, respect, the therapist as a non-expert, meeting individual needs and emotional connection appeared to be valuable concepts that underpinned the therapists clinical practice. It was this type of client-therapist relationship that the therapists identified as lacking in the SFT of de Shazer. This important ingredient of an empathetic relationship appeared to shape the therapists clinical biases.

Therapist experience with SFT and clinical practice -- Subjectively, SFT as designed by de Shazer was not practiced by the research group. Words and phrases such as "eclectic", "not 100%" indicated most therapists were using a modified version of SFT that was unique to each therapist. For many, the opinion was that SFT was not a model, but an approach, a tool, a technique, that was an adjunct to their clinical practice and knowledge base. SFT was not viewed as a new gift, rather as the same gift in "glitzy " wrappings - for most a little too "glitzy", eliciting such responses as "too thin" , "doesn't have a lot of soul", and lacking

integration of the client and therapy as a whole.

The student used the Ethnograph search code of clinical practice across the code for role of therapist. The integration of therapist style and SFT was most clearly indicated with this search. The data suggested that most therapists rejected the impersonal or emotionally distant style of SFT, while adopting only aspects of the model.

One therapist stressed the importance of having a solid general theoretical background before specializing in SFT. Others indicated their use of their own assumptions and own values for the process of change while accepting the "principles" of SFT. Another therapist experienced lingering questions that have yet to be answered by the model. Two therapists indicated a desire and need to do more reading on SFT theory and practice.

The therapists' experience with SFT and their ease or "dis"-ease in adapting to the model appeared to stem from the therapists' knowledge bases. Those who had a strong background in cognitive behavioral, or structural therapies, subjectively described an easier transition to using SFT. It "fit" with their previous style. Those who had a more reflective, Rogerian approach, described greater difficulty and identified a need to make adjustments to the approach in order for it to

suit their individual style. One therapist in particular felt that therapy should be client-centered not model-centered. This is the antithesis to de Shazer's skeleton key approach. However, this therapist did believe that she could modify SFT for use in her practice.

How rigidly the therapists adhered to the SFT format as described by de Shazer, appeared to be influenced by their perspective towards its use in clinical practice. The more flexible the SFT model was viewed, the more the therapists were able and willing to integrate it into their therapeutic style. Prior to the second interview the therapists had the opportunity to attend a workshop by George Enns. In observing his clinical work, which was favorably perceived by the research group, flexibility in SFT was validated. The interview data clearly demonstrated the impact that George Enns had on the therapists at a theoretical and clinical level. The solution focused approach used by George Enns was described as eclectic, understanding, respectful, holistic, and providing the "Canadian way of working". These values were held in importance by the research group.

The research group identified an increased use of SFT over the course of the exploratory research process. For some the change in therapy technique was described as being "more refined" and having a "wider application". It is this student's opinion that the increase in use of

SFT cannot be exclusively related to the research project. The influence of George Enns appeared to be an extraneous factor.

The aspects of the SFT model that were most appealing and fit for most of the therapists were identified as being the positive focus and alteration of the way of thinking. This included the emphasis on the positive, and the use of exceptions and reframing .

A second appealing characteristic that was distinguished was the structure that SFT provided for brief therapy. This structure was identified as giving succinct methods to ask questions and set goals, to provide clear contract boundaries and organization of time, to be consistent and stay focused, quick recognition of areas that required change, and the availability of "therapeutic hooks to hang your hat" when needed. The "rigid" first session format, and the use of the miracle question was neither consistently used or accepted by the research group. Most therapists identified the weakness in their goal setting as their main area that required improvement. Other areas included task assignment, termination, and the use of the miracle question.

The therapists held the belief that SFT was not considered to be appropriate for use with severe psychotic mental illnesses, clinical depression, and those in crisis. Those with a history of severe childhood

trauma or abuse have traditionally been viewed as long-term treatment cases. The research group questioned the effectiveness of SFT with that population. The use of SFT with spousal abuse was a divided issue. This could be a reflection of the varying interpretations as to what constitutes SFT. This uncertainty as to what was actually practiced and measured was endemic throughout this exploratory project.

A concern identified by some of the therapists related to abuse by the SFT model. The uncertainty stemmed from being too "caught up in the positive". This was expressed as the therapist "losing sight" of the whole picture that could possibly result in missing the significance of the client's problems .

Therapists' self-rating scale in proficiency and comfort -- The self-rating responses to the questions of proficiency and comfort indicated to the student that over time the therapists' subjective views changed. All responses indicated an increase in subjective proficiency and comfort in using SFT (see table 4).

Table 4.

Therapists' Self-Rating Scale Scores in Proficiency and Comfort in using SFT.

	PROFICIENCY		COMFORT	
INTERVIEW	1ST	2ND	1ST	2ND
	6	8	6	8
	8	n/s	7	n/s
	5	8	4	8
	5	7	7	8
	8	8	3-4	9-10
	2.5	4	7	7.5
	5	7	5	8

Note. n/s = no score available as therapist did not attend second interview

Therapist Feedback

During the therapists' second semi-structured interview the student acquired feedback on the research project and the examination process. Most therapists viewed the design as providing uniform treatment of the first session. One therapist commented that the use of the research was a "good way" to get the department focused and committed to the SFT format, as over time it was easy to "drift". For some, the research process facilitated goal definition through a more concise format and "kept people on track". One therapist noticed the "shifts" in the thinking of others, as they were more solution focused and worked more within a positive framework.

The therapists' subjective responses to participating in the research project varied. Most felt comfortable with the process and the approach. Some voiced frustration when the cases did not work out, as they felt a responsibility towards the research. One therapist voiced that they had never felt comfortable with the research or the approach. One therapist felt that the research on the effectiveness of SFT was premature, as the therapists needed to learn more about the SFT model, and what makes it work. One therapist voiced anxiety at being video-taped, however noted that it was less difficult to participate in the research once the use of SFT became more familiar. For this therapist it was a challenge to stay on the SFT model as it differed from the

therapist's usual approach. Conversely, one therapist felt that they had quickly outgrown some aspects of the SFT model, and would follow the format only to comply with the research. Some voiced frustration when the format "would not fit" and that there were "too many scaling questions".

Suggestions for future research included looking beyond the first session, as what happens in the following sessions is less clear. Interest was expressed if this model would be helpful for those clients who are considered "chronic" or are repeat customers. How does this approach work for those "difficult "cases, such as sexual abuse survivors who often pose issues of suicidality and are consuming cases to manage? How does this model compare to other treatment interventions? How do we measure if people made changes and do the changes last? Do the clients learn and maintain new skills that assist them in reaching their own solutions? The following chapter on treatment effectiveness begins to answer some of these questions.

Discussion

The therapists appear to embrace a solution focused approach that is adapted to "fit" with their established styles. As such there is little measure of certainty that SFT is being used consistently across therapists due to variation of individual approach. What does this

mean to the agency's delivery of service and the adoption of a unified team intervention?

Without a clear understanding of the treatment intervention being practiced questions are raised. Clearly the therapists value a treatment model that maintains a client-therapist relationship. If the research group is not using SFT, but a solution focused approach, how should that be defined? Feedback from the research group indicates that the use of SFT supplies a common language among the therapists. How does that translate into clinical practice? It appears that part of the answer lies in the focus on the positive. According to de Shazer, clinically this is accomplished through the use of exceptions. This is consistent with the therapists subjective responses but is not supported by the observational measures. The use of exceptions scored the second lowest in frequency next to the assignment of task.

Goal setting was identified by most of the therapists as the prime area that needed improvement. The de Shazer model suggests that goal setting is accomplished through the working of the miracle question. The objective data from the video-taping indicated that the miracle question was almost always used. This suggests to the student, and is supported by some of the therapists' interviews, that there is a complicated art to SFT. A note of caution emerges. However straightforward SFT appears,

in practice it is not as simple as following a recipe that is correct response driven.

CHAPTER 6

TREATMENT EFFECTIVENESS OF SOLUTION FOCUSED THERAPY

This chapter discusses treatment outcomes. The testing of the research subjects extended from January till June 1992. The follow-up telephone contact was initiated in December 1992 and January 1993.

Sample Selection

The research subjects were obtained from the Family Service counseling waiting list and consisted of individuals, couples, and families who agreed to be seen in the SFT approach and consented to research. The population was not randomized. Exclusion criteria were clients who were referred from employee assistance programs, outside agencies and those desiring long-term treatment. There were no restrictions in regard to presenting problems.

Design

Client change was measured in a pre-post-test single system quasi-experimental design and self-anchored scale.

Procedure

Pre-test -- Subjects were asked to arrive approximately 15 minutes prior to their first appointment. Informed consent was obtained by a family services member and the Brief FAM (see appendix H) and Coping-

Stress Questionnaire (see appendix D) were administered at that time.

During intervention -- The self-anchored scaling question was asked during the first session, and at the beginning of subsequent sessions to measure the clients' perceived progress towards change (see appendix E).

Post-test -- The post-tests were administered at the end of the last treatment session by the therapist. Those who completed two therapy sessions remained in the research project.

Follow-up -- Telephone follow-up was initiated by the student with the remaining subjects three to six months following termination. Durability of treatment effectiveness, as well as client satisfaction with the treatment and services that they received were measured. The student used the Brief FAM, as well as the solution focused follow-up questionnaire (see appendix F).

Findings

Request for Services

In the course of six months the research group generated ten intakes who agreed to the study. These initial contacts were made by women ranging in age from 22-42 years. The primary concern stated

was difficulties in significant relationships. Two intakes identified their primary concern as parenting. Two intakes identified depressive feelings as their main concern. Five intakes were seeking individual counseling, three were seeking couple therapy, and two were seeking family therapy. This population was consistent with the counseling service general client base of whom 36% had sought counseling for family concerns, 30% marital concerns, and 28% personal concerns (55th Annual Report, 1991-92).

The ten intake calls generated a subject pool of 14 clients. For thirteen clients this was their first time contact with family services. One intake form did not indicate if there had been previous contact. One case was not included in the study as the client was in active treatment at another facility.

Demographic Information on the 13 Study Clients

Sex and age -- Of the 13 clients who continued in the research ten were female and three were male. The ages ranged from 22-68 years.

Employment -- Seven were unemployed or on social assistance, four were employed on either a full time or part-time basis, one was retired, and in one case the employment status was not documented at intake.

Marital status -- Four of the clients were married, three were separated, one was widowed, and five were single.

Course of Treatment

Number of sessions -- Eight of the 13 clients attended three sessions or less (61%). This was fairly consistent with Kiser (1991) and Garfield (1986) who stated that just over 55 % of clients attended three or less sessions. Seven cases did not extend past one session. These cases either did not return for scheduled sessions, or another treatment intervention was used in addition to the SFT approach. This data lent credence to de Shazer's claim that the modal number of sessions, for most clients either by plan or "default", was one. Kiser (1991) in his paper that evaluated the relationship between treatment length and goal achievement of SFT cited 20 out of 31 (60%) single session clients reported at follow up they had made gains towards or obtained their treatment goals. As the single session cases were excluded from the research project at FSI, follow-up was not undertaken. This would be an interesting avenue to explore for future research. De Shazer often claimed treatment success following one session, however without investigation of this assumption support for Kiser's results cannot be made from this project.

Overview of Pre and Post-test Results

The final subject pool comprised six cases. Five female and one male. The cases are identified as A, B, C, D, E, and F. Due to this small sample size statistical significance cannot be inferred. The findings are suggestive rather then conclusive.

Session Range, Average and Mode

The range in number of sessions was from two to 12 appointments. The average number of sessions was 5.8, however this number was skewed due to the 12 session case. The modal number of sessions was four. These results are lower than previous brief therapy research as described by Weakland et al. (1974) where the average number of sessions was seven. Garfield (1986) in his review of client variables in long-term psychotherapy concluded that "most clinic clients remain in therapy for only a few sessions". The modal number of four sessions reached at FSI correlated closely to research done at the BFC in Milwaukee where treatment goals were obtained, and therapy was terminated "typically within five therapy sessions" (Kiser, 1991).

Coping-Stress

Pre and post test results on the Coping-Stress Questionnaire were available on six of the cases. When these cases were presented as an aggregate there is little difference between the mean pre-test score

(84.33) and the post-test score (83). The scores indicate only slight movement towards the positive. This can be explained more fully when the sub-scales of depression and mastery are examined. The mean pre and post-test scores of the mastery sub-scale indicated that there was movement of almost two measures towards the negative. The mean pre-test score was 28.16 and the mean post-test score was 29.5. Conversely the pre and post-test mean scores of the depression sub-scale indicated a positive movement of almost three measures going from a mean score of 28.83 to 26. The differing direction of change as measured by these two sub-scales accounts for the little difference between the total pre and post-test scores.

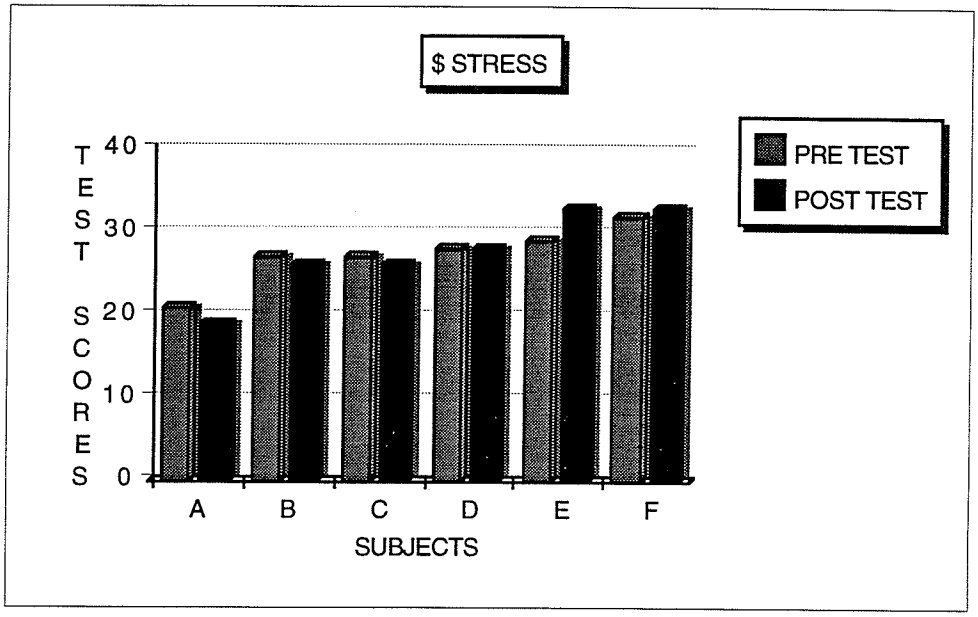
The mean pre and post-test scores of the economic-stress sub-scale were virtually unchanged, with the pre-test measure averaged at 27.33 and the post-test measure averaged at 27.5. This consistency was also reflected in the individual scores where four of the six cases indicated a movement of two or less measures, and one score indicating no movement (see figure 5). The one exception was case E, where the post-test score was four measures greater, indicating greater economic strain following the SFT intervention. As the presenting concerns were predominately relationship oriented, it would follow that the economic stress measures would show little movement.

Brief FAM

The average raw score of the Brief FAM pre-test was 31.4, compared to the post-test average of 27.6. This difference suggests a positive movement towards change following the SFT intervention. As the Brief FAM provides comparative norms, these results indicate a movement from a clinical population (30.4) to that of near norm (27.3).

FIGURE 5. Economic-Stress Sub-Scale Bar Graph

Bar graph of the pre and post-test scores of the economic-stress sub-scale of the Coping-Stress Questionnaire. Subjects = Cases.



Single-System Analysis

Slonim-Nevo and Vosler (1991) argued that there is a "goodness of fit" between brief problem-solving systemic therapy and the evaluation of experimental single-system design". Bloom and Fischer (1982) expounded on the importance of single-system design in evaluating clinical practice.

Coping-Stress

Visual analysis of the Coping-Stress bar graph seen in Figure 6 indicates that four of the six cases (A, B, D, & F) show movement towards the positive. This positive movement ranged from three to 11 measures. If one concedes that the Coping-Stress Questionnaire is sensitive to change, then the results indicate treatment effectiveness for 67% of the cases.

Visual analysis of the mastery sub-scale as shown in Figure 7 indicates that two of the six cases (C and E) scored higher in their post-test score by seven measures. This clearly indicates that 33% of the cases identified less sense of mastery of their environment following the SFT intervention. Almost no movement was shown between the pre and post-test responses for cases A, B, and D. Case F showed positive movement of three measures. Assuming the instrument had good construct reliability, the findings provoke some interesting

speculation as to what is the agent of change in the SFT intervention. The mastery sub-scale items, at face value, appear to be related to control of one's environment, with the underlying theme of hopefulness (see appendix D, items 1-15).

Visual analysis of the depression sub-scale bar graph indicates that four of the six cases (A, B, D, and F)(67%), show improvement in their mood (see figure 8). One case indicates a positive movement of six measures, and another one of nine. The initial findings could suggest that one's mood is impacted by the SFT intervention. This may support the theoretical link between the instillation of hope and positive framework being an active agent of change. However, this perplexes the student, as there would appear to be a correlation between a greater sense of mastery and improved mood. This psychological construct has been supported by past research that examines one's perceptions of locus of control (mastery) and depression. The inclusion of the Beck Depression Inventory and Multidimensional Health Locus of Control Scale are suggested measurements for future SFT research.

Brief FAM

As figure 9 demonstrates, four of the five post-test scores (80%) indicate movement towards the positive. Two cases indicate movement as great as 10 and 12 measures. Three of the five cases had pre-test

scores that indicated a clinical population while their post-test scores indicated normal functioning upon termination of the SFT intervention. Two cases indicated scores in the clinical range on the post-test measures.

Self-Anchored Scale

Five of a possible six self-anchored rating scale forms had been completed by the therapists (one therapist did not complete the form). The five completed forms had scores that indicated client movement towards "where they wanted to get to" at the first session interview (see table 5). The range of the responses on the scale of ten were from two to seven with the average subjective response being four, and the modal number being two. These results were consistent with the theoretical understanding of SFT's continual change and client movement towards health before the first session. When the self-anchored scale scores from the first session were compared to the final sessions, two scores indicated no movement from the initial session, two scores indicated a movement of two, and one score indicated a movement of one. Three of 5 cases (60%) showed positive movement following the SFT.

In summary the Brief FAM, Coping-Stress, and self-anchored scales supported a 60% and greater success rate post SFT intervention.

FIGURE 6. Coping-Stress Bar Graph

Bar graph of pre and post-test results for the Coping-Stress Questionnaire. Subjects = Cases.

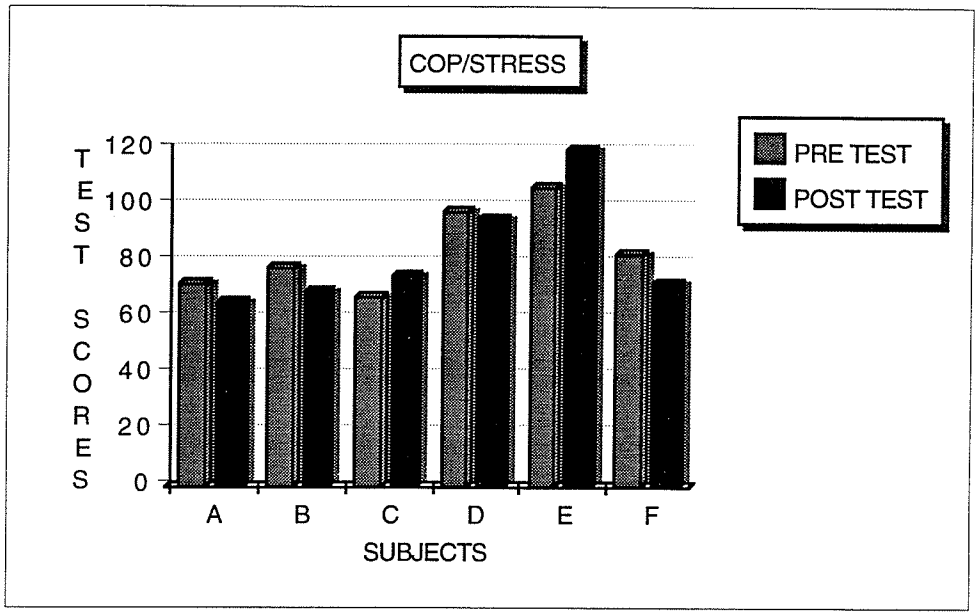


FIGURE 7. Mastery Sub-Scale Bar Graph

Bar graph of the pre and post-test scores of the mastery sub-scale of the Coping-Stress Questionnaire. Subjects = Cases.

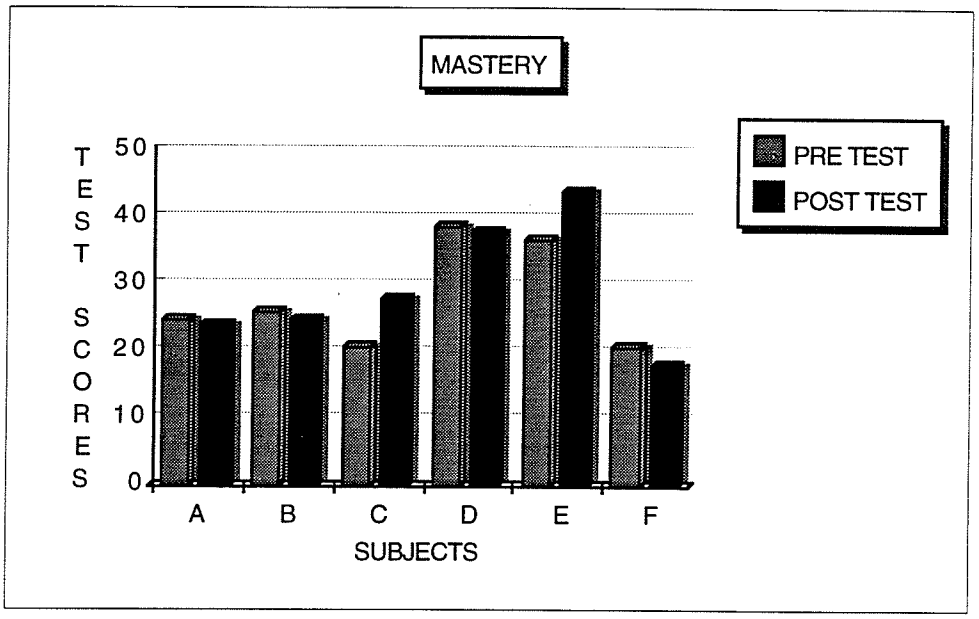


FIGURE 8. Depression Sub-Scale Bar Graph

Bar graph of pre and post-test scores of the depression sub-scale of the Coping-Stress Questionnaire. Subjects = Cases.

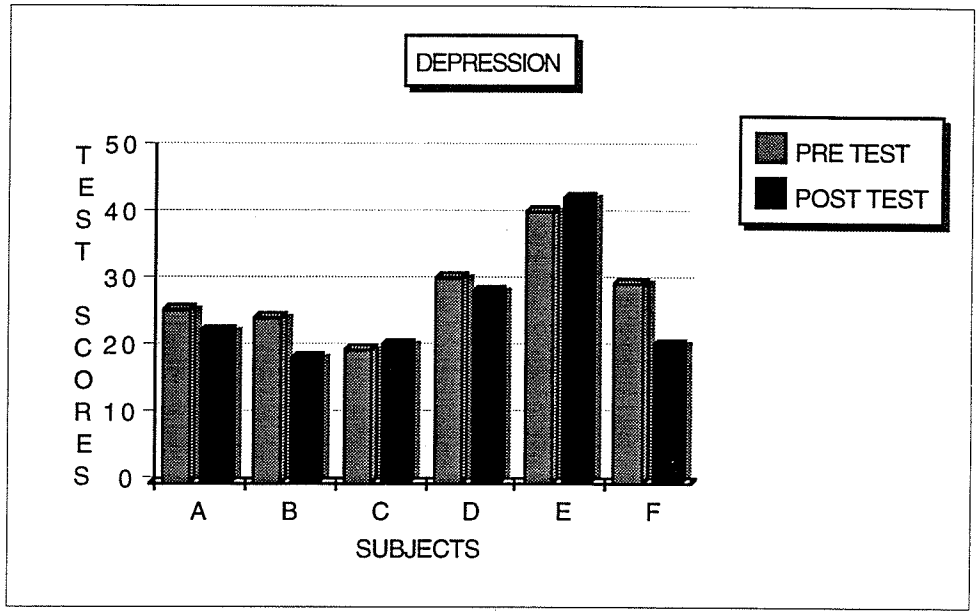


FIGURE 9. Brief FAM Bar Graph

Bar graph of pre, post and follow-up test scores of the Brief FAM.

Subjects = Cases. .

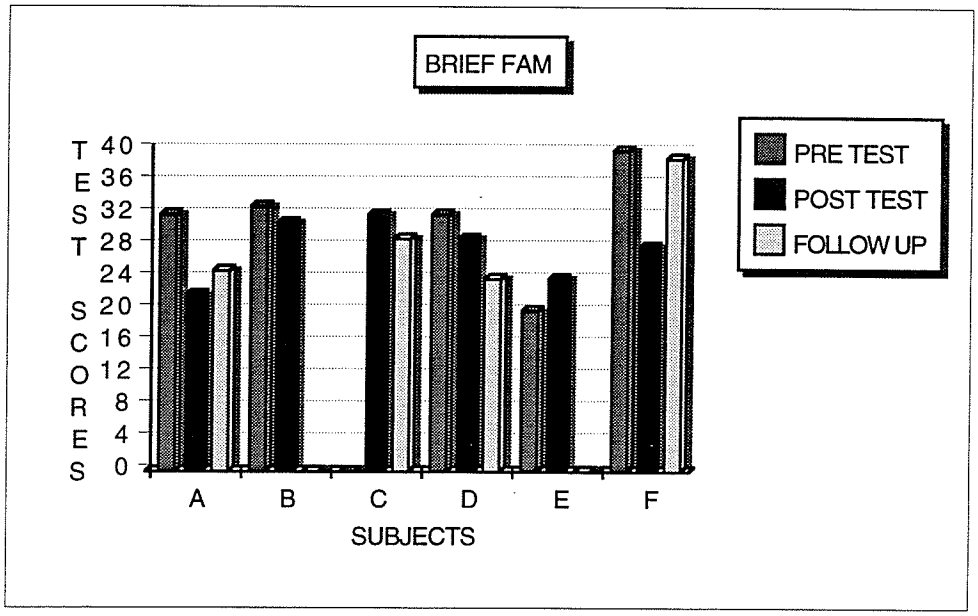


Table 5.

Client Self-Anchored Rating Scale Scores

	SESSION		
CASE	**First**	**Final**	**Follow-up**
A	4	4	9.5
B	2	3	N/S
C	7	9	8
D	2	3-4	4
E	5	5	N/S
F	N/S	N/S	5.5

Note. n/s = no score

Scores were from first, second, and final session

Follow-up

The student had attempted to contact the six cases for the follow-up portion of the research project. One of the cases was contacted three months after the termination of the therapy and the remaining three cases six months post-therapy. Two cases were not available by phone. Follow-up information was gathered on cases A, C, D, and F.

Self-rating scale -- Follow-up scores were available on four of the six cases (see table 5). All scores indicated positive movement from the time contact had been initiated with FSI. Two cases indicated almost total resolution of their problems with scores of eight and 9.5. Although not statistically significant, these results do suggest clinical significance. The cases that supply complete data indicate that treatment durability was subjectively maintained at least three months post intervention. The follow-up scores indicate that no cases had deteriorated to the point of when they first sought intervention, and could suggest generalization or incorporation of the treatment strategy to new situations. The use of the self-anchored scale could prove to be helpful in later research designs.

Brief FAM -- The mean Brief FAM follow-up score was 29.25. This was just below the clinical indication guideline of 30.4, and showed a negative movement of almost two measures when compared to the mean score of the post-test Brief FAM. The individual follow-up scores from the

Brief FAM indicated treatment durability with three of the cases, as these scores remained within the normal population (see figure 9).

SFT Post-Treatment Follow-up Questionnaire

All four cases indicated that they had not met their goals at the time of termination. Termination for three of the cases was influenced by the feeling of not "getting anywhere".

All cases indicated that their problems were as bad to them as they thought. All cases felt that their friends, relatives or partners were supportive of their seeking help.

No clients specifically commented upon the SFT approach. Two clients indicated that they did not like the type of therapy used, however, this was in reference to the therapist style. One client indicated that she thought she could get better help elsewhere.

There was no indication that the team approach was disliked by the clients. Comments that the clients made included a feeling that the team approach was most helpful, especially after the therapist had consulted with the peer group. Two clients felt that by using the team, there was more input, making it a more positive experience. Of these two clients one indicated that if needed in the future she would "call again".

One case indicated that she wanted to seek additional help but was hindered by time constraints. Instead she utilized her friends as supports. One case indicated that she received support from a three month training program designed to assist acquiring full time employment.

The first four questions on the SFT follow-up proved to be the most informative. The responses to these questions are depicted on table 6. The questions explored were:

1. The concerns that brought the client into treatment as being same, better or worse.

2. The self-anchored rating scale towards resolution of problems from the time of contact with the agency.

3. The identification of other aspects of the client's life being better, same or worse.

4. The need to seek additional help. These responses were obtained either three or six months post SFT intervention.

The responses indicated that subjectively three cases were doing better since the SFT intervention. Two of the four cases indicated almost complete resolution of their problems. Three of the four cases did not seek additional services. The first question indicated that three of the four clients had contacted family services to assist them in relationships

with their partners, or with other family members. Of these three, all indicated an improvement in their initial concerns, and that generally other areas of their lives had been going "better than expected ". This 75% success rate was consistent with the results obtained by Weakland et al. (1974), de Shazer (1986) and Kiser (1991) in response to the same question. This rate is somewhat lower then the rates that FSI reported of 82% (55th Annual Report, 1992). The student recognizes that this difference may be attributed to the data gathering methodology that relied upon the clients to mail in responses. That may give a false positive response as clients who are unsatisfied with services may not follow through in returning the client satisfaction questionnaire.

Table 6.

Responses to Questions 1 to 4 on the SFT Follow-up Questionnaire. .

Case	Question #1	#2	#3	#4
A	**BETTER**	9 .5	**BETTER** THAN EXPECTED	NO
C	**BETTER**	8	**BETTER** THAN EXPECTED	NO
D	**SAME**	3 - 4	WORSE	YES
F	**BETTER**	5.5	**BETTER** THAN EXPECTED	NO

Note. No data collected on Cases B and E

Case Analysis and Discussion

Case A -- Case A initiated contact with FSI for concerns of deteriorating marital relationship. Her spouse had a "drinking problem", and she would respond in frustration becoming physically violent. Her pre-test Brief FAM score was within the clinical range. She attended five sessions. The post-test scores on the Coping-Stress Questionnaire, and Brief FAM showed positive movement towards health. Of significance the post Brief FAM score was within normal population range. At follow-up Case A indicated that treatment had been terminated prior to the meeting of all her goals. The follow-up Brief FAM indicated treatment durability six months post treatment intervention. Subjective measures were consistent with the objective data. Since the termination of therapy case A indicated that no new problems had developed, things were going better, and almost complete goal attainment had been achieved. Case A indicated a decrease in alcohol abuse by the husband following the SFT intervention. The husband was identified as staying home more. Case A described her experience at FSI as "good", and if needed would call again in the future. To summarize, the subjective and objective data gathered on Case A was congruent. She indicated improvement and maintenance of change post SFT intervention.

Case B -- Case B attended FSI for concerns of a deteriorating marital relationship. He had a "drinking problem", and his spouse would

respond in frustration becoming physically violent. Case B's pre-test Brief FAM was in clinical range. He attended four sessions. His post-test scores indicated a positive movement of eight measures on the Coping-Stress Questionnaire with positive movement of six measures on the depression sub-scale. The post-test Brief FAM indicated a positive movement of two measures, however it remained in the clinical range. Case B's subjective responses on the rating scale indicated minimal movement towards goal attainment with a first session score of two, and a last session score of three. Although the student was not able to have direct contact with case B, the behavioral observations made by the spouse could indicate a movement towards health. In summary, Case B's objective and subjective data appeared to be congruent. It indicated improvement post SFT intervention, but concerns remained in the clinical end.

Case C -- Case C's concerns for seeking services included family of origin issues, and parenting skills. She attended 12 sessions. Her post-test Coping-Stress score indicated negative movement of seven measures, and and her post-test Brief FAM indicated a score in the clinical range. These measures did not support her subjective scaling response that placed her at a nine towards total resolution of goals at her last session. In follow-up Case C again presented an interesting picture. She indicated a high score of eight towards total resolution of her goals,

and voiced that things were going “better than expected”. Her Brief FAM score was in the normal range. Case C felt that there was improvement in her concerns since the SFT intervention, however she was hesitant to attribute this to her counseling experience. She did feel that it was beneficial to "air " problems, but indicated that she could get better help elsewhere. She stated that her therapist always gave her point of view. The client found this distressing. She also felt that the therapy was "going in circles", and she could not get near to what she wanted to resolve. Case C was not totally satisfied with her experience. She felt that she needed “someone different”, and more guidance in the form of “advice" or teaching of coping strategies. Case C indicated that there were “always ongoing things”, and that she had considered phoning the agency but did not wish to return. In summary, Case C’s subjective and objective data at follow-up indicate movement towards goal resolution and health. However it is difficult to attribute change relating to the SFT intervention due to Case C’s subjective responses.

Case D -- Case D sought family service intervention for family of origin issues, and concerns about parenting skills. Her pre-test Brief FAM was in clinical range. She attended four sessions. Case D showed gradual improvement over time. The post-test scores indicated positive movement towards health. The most significant being that the Brief FAM went from clinical to normal population standards. This standard was

maintained with the follow-up objective measure indicating six months of treatment durability. The subjective measures were not consistent with the objective data. At follow-up Case D did not perceive any change in her concerns since her first contact with FSI and felt that generally things were going worse. She indicated a low score (3-4) on the self-anchored rating scale towards problem resolution. Since her contact with FSI she stated that she felt "the same" in certain areas of her life and would still "worry a lot". This client's experience was that she could not relate to therapist, and assumed much of the blame by feeling "stupid". Client D terminated therapy because she did not like the type of therapy. She indicated that perhaps her therapy did not "get anywhere" because she could handle her problems on her own. In summary, case D's subjective and objective data was not congruent. Objectively, she showed improvement with her Brief FAM going from clinical to normal range. Subjectively, she did not perceive herself near to the attainment of her goals. When asked what part of therapy was most helpful, Case D responded "no part". The negative picture painted by Case D towards her intervention experience cannot be fully explained by the objective measures used. She did score the second highest in the depression sub-scale. This could suggest an accompanying negative attitude or "tunnel vision".

To better understand the discrepancies presented by Case C and

D the incorporation of the Beck Depression Inventory and/or characterlogical measurements could prove informative. It would be interesting to measure what does not change during the SFT intervention. These two cases underscore the question "What constitutes treatment success? Should different outcome measures be emphasized? Should treatment outcome be measured with the emphasize on objective responses for those clients who have profiles similar to Case D? In that case example, subjective measures appear to have a higher probability of predestined failure.

Case E -- Case E sought couple counseling due to being in a physically abusive relationship and having communication problems with her partner. Her pre-test Coping-Stress score was elevated, especially on the depression sub-scale. She attended two individual sessions. Her post-test Brief FAM and Coping-Stress scores indicated negative movement of 4 and 13 measures respectively. Her subjective response of five towards goal resolution remained unchanged for her first and final session. Follow-up was not possible due to frequent changes in residence. In summary, one can conclude that Case E did not show clinical progress post the SFT intervention. It is the student's opinion that this case is a good example of the challenges made against the constructivism theory, and does not support de Shazer's skeleton key model. Those in actively abusive relationships require environmental

conditions that will support therapeutic intervention. This case also ranked the highest scores on the depression and mastery sub-scales, indicating possible clinical depression and need for more intensive intervention.

Case F -- Case F sought services due to difficulty with her past partner and stresses at being a single parent without a support system. The pre-test Brief FAM was well into the clinical range. Case F attended four sessions. The objective post-test measures indicated significant movement towards health following the SFT intervention. The Brief FAM made a positive movement of 12 measures and the Coping-Stress a positive movement of eleven measures. The three month follow-up objective measures indicated that intervention durability was not present. The Brief FAM score was in clinical range and only slightly lower than the pre-intervention score. However subjectively, case F indicated that her concerns were going better then when she first contacted FSI, and indicated a score of 5.5 towards problem resolution on the anchored self-rating scale. She identified the SFT intervention as being helpful in her return to school. She described new difficulties that had arisen from court proceedings against her ex-partner, however she felt confident that she had met this challenge. In summary, the subjective data on follow-up was not congruent to the objective picture. This could be explained as the client wishing to please the interviewer.

Discussion

Schulberg (1981) stated that in the absence of rigorous experimental design the "central significance is whether the therapeutic interventions can be causally linked to the client's post-treatment". The student's initial impression is to suggest that the link between SFT intervention and favorable outcome results are present. The post-test results of the Coping-Stress, Brief FAM and self-anchored rating scales in at least 60% of the cases indicated positive movement towards health. It is the student's opinion that these findings have clinical significance.

Bloom and Fischer (1982) discussed the criterion of causal inferences that include: 1) temporal arrangement (change occurs after intervention); 2) the co-presence of intervention and change (no intervention = no change); 3) repeated intervention equals repeated change; 4) need to rule out other possible influences on outcome; 5) consistency overtime; and 6) conceptual and practical plausibility (what formulates the hypothesize). Nelsen (1981) discussed change in client's environment, maturational effects, changes in treatment environment, change in therapist attitude, and reaction to being video-taped or observed as factors threatening internal validity. Using these more rigorous guidelines, it is the student's opinion that it is difficult to infer the casual link between the SFT intervention and treatment outcome due to the experimental design and threats to internal validity.

To increase the casual inference of SFT, the use of a multiple baseline design would provide greater control for internal validity. To this end, measures such as the Brief FAM and Beck Depression Inventory are recommended by the student. As discussed by Kazdin (1986) "the immediacy and the magnitude of changes are the two most salient dimensions (of treatment effects)". Therefore any immediate indication of change increases one's ability to infer that the change is related to the intervention and downplays the threats to internal validity. The inferences made about treatment effects are further strengthened as the likelihood of extraneous events covarying with treatment across a heterogeneous population are low. "As the diversity and heterogeneity of the clients and the conditions of treatment increase, it becomes increasingly plausible that the common experience shared by the clients (treatment intervention) accounts for the changes" (Kazdin, 1986).

There exists the need to indicate that the intervention was delivered as defined. The researcher feels confident that the the first session of SFT was used consistently, however, in subsequent sessions the influence of other treatment interventions was not controlled. Thus the treatment effectiveness of SFT cannot be inferred.

The case by case analysis paints a unique picture of each clinical intervention. Although small in size, the research provides the beginning

steps toward further exploration of the type of client that SFT appears to be most effective for and the essential pre-requisites for change to occur. When one compares the post-intervention outcomes between Case A, and Case E, one can speculate that a supportive environment needs to be present for intervention to be successful. Measures of personality maybe helpful in better understanding the differences between subjective and objective outcome results as presented in cases C, D and F. The subjective and objective differences raise questions as to the follow-up studies discussed previously by this student that indicated a 75% success rate (Kiser, 1991; Weakland et al., 1974). Without multiple measures, the student questions the high success rates from those studies. Are they are a true measure of treatment effectiveness, or of the client's desire to please the researcher?

The data suggests that those cases who attended four or more sessions exhibited greater treatment durability. This is consistent with Kiser (1991) who in his follow-up study concluded that "clients who receive four or more sessions of therapy make significantly more progress than those who receive three or less".

The self-anchored rating scales indicate change prior to treatment intervention. Bloom and Fischer (1982) who are well versed in clinical

evaluation stated the "heart" of research is the underlying assumption that if the intervention did not occur, baseline patterns would remain the same. If change is measured before intervention, then the active ingredient(s) for change is(are) unknown. De Shazer's philosophy of change being a continual process and occurring before intervention is reflected by the results of the self-anchored rating scales. These results pose a challenge to both de Shazer's claim of treatment success after one intervention, and to the foundation of traditional research design. The results support the old adage that "time heals all wounds", while making casual inferences more difficult. De Shazer's claims of treatment success after one session may in fact be a function of time.

CHAPTER 7

RESEARCH EVALUATION

Were the goals met?

To assess the success of this research project the operationalized goals were reviewed. It is the student's opinion that the examination of the application of SFT at FSI provided valuable insights to (a) how SFT "fit" for the therapists, (b) how SFT can provide a unified treatment approach, and (c) the laying of the groundwork for future research evaluation.

Goal 1. -- To identify the degree and direction of change using the constructs of coping as measured by depression, self-mastery, economic stress and family functioning.

Yes. Although far from conclusive, the initial results suggest positive change in the areas of individual mood, and family functioning. The concepts of financial stress, and self-mastery did not appear to be impacted. These rudimentary findings suggest areas to be explored for future research.

Goal 2. -- To measure the effectivness of SFT, and to assess individual treatment success through subjective and objective measures with outcome being a measure of program success.

Yes. Responses to the follow-up questionnaire show three out of

four clients doing "better". This was comparative to the research done by Kiser (1991) and Weakland (1974) who suggest these measures indicate treatment success. Greater than 60% of the cases made positive movement post intervention. These results are not statistically significant, nor can any causal link between intervention and outcome be inferred. However, they are of clinical significance. In this research project treatment success is one measure of program success.

Goal 3. -- To increase the therapists proficiency in the utilization of SFT through the development of a first session observation form.

Yes. Objective data gathered on the first session format indicated consistent use of the components of SFT. It is the student's conclusion that this focus was beneficial for those therapist in the research group who wished to practice SFT. Some would not have adhered to the to the rigid format had it not been for the research. For the former, that was positive, as they were compelled to put more effort into using the approach consistently. For the latter this was viewed as negatively impacting on their clinical practice. The therapists self-anchored rating scale indicated greater comfort and proficiency in using SFT.

Goal 4. -- To evaluate research success as determined by agency identified goals.

Yes. It is the student's opinion that the evaluation project met the identified goals that are being discussed.

Goal 5. -- To determine the therapists satisfaction with SFT through the use of semi-structured interviews.

Yes. This aspect of the research was most informative for the student. It is the student's opinion that the de Shazer SFT model did not fit with the therapists' philosophy of client-therapist relationships. What did emerge was the belief that this relationship is a salient component to the intervention experience. The therapists highlighted the need to be connected to their clients. This "fit" with the follow-up data that indicated three out of the four clients' value of therapy was related to the relationship they had with their therapist. The "type"of therapy did not appear to impact with the clients. The student concludes that there is a lack of acceptance of the de Shazer model of SFT by the therapists at FSI. There is no indication that it's use continues consistently past the design of the first session. Nor is there indication that the research group is unified in pursuing SFT as intended by de Shazer.

Discussion

The close examination of one's clinical practice is seldom attempted due to weak technology, lack of professional backing, and limited experience by the clinician/researcher. Despite this, Bloom and

Fischer argue that administrators do not have the choice of whether to evaluate or not, only a choice of the kind of evaluation (1983). Examination of treatment and program evaluation are an important part of staff development and have direct impact on service delivery.

The inherent difficulties with the examination process have been discussed by Lind and O'Brian (1971). These authors identified factors such as output goals not being identified, "threat to personnel", communication differences between research group and personnel, cost of evaluation, resistance to use experimental design by the service providers and lack of individual experience on the part of the researcher that makes program evaluation research difficult and appear to be less scholarly.

The student's experience as a formative researcher encompassed some of these difficulties that contributed to the small sample size, and incomplete data. "Perhaps the greatest challenge in initiating an evaluation process in clinical practice settings lies in the resolution of the human reaction of family therapists to any procedure of service quality assessment" (Trute, 1985). As the research project commenced the operationalizing of the first session format, the level of anxiety in some therapists increased. Therapists expressed the concern that the research was becoming "too wrapped up " in adhering to the SFT model,

and that this might be to the detriment of the clients. The ethical dilemma of subjecting clients to research during times of stress is a well documented chasm between practitioners and researchers.

The introduction of the evaluation of practice placed the therapists in an unfamiliar position. Often in therapy a variety of interventions are used that are “automatic” responses. It is no easy task to allow oneself to be evaluated as to adhering to a specific criteria. "To what extent do we sacrifice our own styles to accommodate this model ?" and "How much do we want to use this model in our agency?” are honest responses to the exploration of clinical practice. The student was initially surprised at these responses. As a neophyte researcher, the student had made the erroneous assumption that the therapists had accepted SFT. It is the student's opinion that the therapists felt the appealing pull of SFT. Some of the therapists had been baited and hooked by its powerfully persuasive language. As the research continued and the influence of George Enns was experienced, SFT as practiced by de Shazer was not maintained.

Following the basic premises of systems theory, any change to part of the system will impact on the system as a whole. The student was an extraneous factor to the agency, and views this an impacting on the process of evaluation research. The decision was made to not actively

pursue the completion of forms. It is the student's opinion that this was helpful to the understanding of the research design. The simultaneous research at different levels proved to be complicated, and was most likely a factor that contributed to the low number of cases, and incomplete data gathering. In an attempt to be a formative evaluator that addressed and incorporated the agencies agenda, the clarity of the research became obscured.

At the larger systems level, the evaluation could perhaps be described as reflecting the transitions that were occurring at the time. The question as to the agencies executive director had not been resolved. The demand for the therapists to generate greater hours of direct client contact stressed clinical practice. Time to dedicate towards the completion of research forms, remembering video-tapes, etc. was an added strain. Trute (1985) discusses the need to create a supportive agency environment to assist the therapists' motivation to maintain data gathering. It is the student's opinion that a greater preparation phase was needed. Spending more observational time at the agency would have increased the student's familiarity to the therapists, promoting a greater level of comfort. Had the student spent more time in gathering baseline data, such as following one case from beginning to end, some difficulties that arose may have been anticipated.

CHAPTER 8

CONCLUSION

To the evaluation researcher, ultimate success is achieved when outcome can be closely tied to process (Trute, 1985). It is the student's opinion that this project could be the beginning steps of strategic planning for a program evaluation infrastructure at FSI. The differing of theoretical acceptance, and adherence to the SFT model by the therapists at FSI have clinical implications for service delivery. A need exists to evaluate the components of the treatment intervention being practiced. Outcome measures should reflect the intervention strategy. The therapists continued growth towards a more flexible approach, like that of George Enns, should favor didactic measures that look at family boundaries.

Theoretically, SFT can be viewed as a constructivist based approach that incorporates the therapist as part of the system. The applications of the "miracle question", cognitive restructuring, pacing, and "language games", are familiar techniques reworked into a framework that is clearly stated. This structure is indeed appealing, as it is empowering to the therapist by providing treatment tools. However simply stated the format appears to be, and despite the ease at which success appears to be achieved, the level of skill required to effectively

use SFT should not be underestimated. As this innovative technique increases in use, so should be the generation of research into SFT's effectiveness as a brief therapy.

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Appendix A

Solution Focused Therapy First Session Observational Tool

First Session Observation Form

Name of therapist_____ Date_____

Family name _____

PLEASE RATE THE FOLLOWING AREAS

KEY:

not at all	partially complete	almost completely	completely
(1)	(2)	(3)	(4)

1.Statement of the problems (What brings you here today?)

(1) (2) (3) (4)

Comments_____

_____

2.Miracle question (the problems that you brought here today are solved)

(use of "what else?") (use of relationship questioning)

(1) (2) (3) (4)

Comments_____

_____

3.Statement of the exceptions

(1) (2) (3) (4)

Comments_____

_____

4. Scaling questions: a) "From the time you called ?"

b) confident/hopeful for change

c) willingness for change

(1) (2) (3) (4)

Comments_____

_____

5. Use of compliments throughout the session

(1) (2) (3) (4)

Comments_____

_____

6. Assigned task

(1) (2) (3) (4)

Comments_____

_____

7. Objective level of comfort of the therapist in using SFT

not very comfortable very comfortable

(1) (2) (3) (4)

Additional comments_____

_____

THERAPIST'S SUBJECTIVE LEVEL OF COMFORT AND COMMENTS AFTER FIRST SESSION

THERAPIST'S SUBJECTIVE LEVEL OF COMFORT AND COMMENTS AFTER LAST SESSION

Appendix B
Exploratory Semi-Structured Interview Questions of the Research Group on SFT

Solution Focused Therapy Therapist Questionnaire

Name of therapist_____ Date of Interview_____

1. Please describe your experiences with Solution Focused Therapy ? I

2. Do you believe SFT is effective in promoting change ?

3. How do you understand SFT as being effective ? What do you believe "works" with this intervention and how do you believe it works ?

4. How does your role as a therapist "fit" with this model ?

5. With your current experiences do you feel that there are certain situations or clients that do not "fit" with the SFT intervention ?

6. On a scale of 1 to 10, how proficient do you feel in using SFT ?

7. On a scale of 1 to 10, how comfortable do you feel in using SFT ?

8. Do you identify aspects or areas of practicing SFT that you feel needs improvement ? Explain.

9. Additional comments. (2nd interview- How would you describe your experiences with this evaluation research ? Explain)

Appendix C
Evaluation Research Outline of SFT at Family Services

Research Outline

Thank you for participating in this research project.

This research project is a pilot study. It's purpose is to lay the groundwork for a more comprehensive method of program evaluation at Family Services Inc. The initial conceptualization of the research was to measure the effectiveness of solution focused therapy as a means of program evaluation. Through a series of discussions the research has transformed in order to best accomplish this initial intention.

The project has been divided into two dimensions that are very different, but very related. The first dimension of the project addresses the delivery of Solution Focused Therapy. In order to evaluate the effectiveness of a particular approach that approach must be used uniformly across individuals and time. Solution Focused Therapy identifies the first sessions as the apex of the therapy. It requires the therapists to follow a recipe that must include certain ingredients. The ingredients that the team have identified as essential components are listed on the First Session Observation Form. The purpose of this form is to (a) supply a more formalized method of on-going program evaluation; (b) provide a measure of treatment consistency among therapists and

over time; (c) provide a means of enhancing individual proficiency in the use of Solution Focused Therapy.

The second dimension of the research project addresses the clinical effectiveness of solution focused therapy as a measure of program evaluation. This will include (a) the pre and post intervention measures that will attempt to identify change in the client; (b) a follow-up questionnaire that addresses intervention durability, the client's perception of therapy, satisfaction of the services received and identification of goal attainment as a measure of treatment and program success.

Procedure

The consent to treatment and the pre and post questionnaires will be located in a designated office at Family Services. The numbered questionnaires, along with the consent to participate, and the recording form of the scaling question, will be placed in numbered folders. The consent will not be numbered. This method is to enhance client confidentiality. However, as pre and post measures need to be compared, and as follow-up contact is required, the client's identity is needed to be known to the researcher. Therefore the therapist will record the number of the folder and the client's agency number in the provided log book. The log book will be kept in the designated research office.

Each folder will contain two envelopes. The envelope identified as the "pre therapy" will contain one consent to participate in the research project, one form to record the scaling question, two copies of the Coping-Stress questionnaire for adult clients (18 years and older), and two "self-concept" scales for children (8-17 years of age), and four Brief FAM (ages 8 and up). ***If a child is under eight years of age they will not be included in the research measurements***

The "post therapy" envelope will include two copies of the Coping-Stress questionnaire for the adult clients (18 years of age and older), and two "self-concept" scales for the children (8-17 years of age), and four Brief FAM (ages 8 and up).

Initial telephone contact Once the therapist has identified a client that is willing to participate in the solution focused team approach, the therapist will ascertain the client's willingness to participate in the research study. ***The refusal of a client to participate in the study will in no manner effect the services that they receive***

In-person contact. If the client gives verbal agreement over the phone they will be asked to arrive 20-30 minutes before their scheduled appointment. This will allow further discussion of the research project, the consent to be signed, and the pre therapy questionnaires to be

administered. The envelope marked "pre" should contain all required items.

*** Please document on the consent form the family members who are present and who the consent encompasses ***

*** Please reinforce to the client that they may withdraw at anytime ***

The the therapist will place the signed consent in the agency's file, will log the client research number and corresponding agency number, and will place the research file (which will now contain the completed questionnaires) in the research office.

*** Extra questionnaires will be available in the office and will required to be numbered***

In session The therapist will use solution focused therapy and will ask the client scaling question "From the time you called where are you now ? in each session to identify the client's movement towards change. The number for the client will be recorded on the scaling form that will be kept in the agency chart until the file is closed. It will then be included with the other gathered data.

The team. The team who are observing the sessions will be responsible for completing the First Session Observation Form and for video-taping the first session. The tape and the form will be locked in a sealed envelope in the designated research room. The researcher will view the tape and the form and return it to the therapist each week.

*** The therapist is responsible for supplying the tape, and informing the team that it is the first session ***

***The team will remind the therapist to ask the scaling question in following sessions ***

Closure of a file At the completion of the therapy the clients will be given the post-measures by the therapist. The forms will be placed in the envelope marked "post". The completed measures will be placed in the client's file, and the therapist will document on the log that the file is now completed or closed.

Appendix D

Stress-Coping Questionnaire (Adapted from The Structure of Coping, Pearlin and Schooler, 1978).

Research #_____
Date:_____
Age:_____
Name: (please use initials only)_____

Family Member:
Mother_____
Father _____
Other _____

Here are a set of statements that tell how people feel about themselves. Please check your response to each statement which most closely describes your feelings at this time. There are no right or wrong answers. Please answer every question.

	Almost Always	Most of The time	Some of The time	Not at All
1. There is really no way I can solve some of the problems I have .				
2. I feel that I am being pushed around in life.				
3. I have little control over the things that happen to me.				
4. I can do just about anything I really set my mind to.				
5. I often feel helpless in dealing with the problems of life.				

	Almost Always	Most of The time	Some of The time	Not at All
6. What happens to me in the future mostly depends on me.				
7. There is little I can do to change many of the important things in my life.				
8. I feel that I am a person of worth at least on equal with others.				
9. I feel that I have a number of good qualities.				
10. All in all, I am inclined to feel that I am a failure				
11. I am able to do things as well as most people.				
12. I feel that I do not have much to be proud of.				
13. I take a positive attitude towards myself.				
14. On the whole, I am satisfied with myself.				
15. I certainly feel useless at times.				
16. I wish that I could have more respect for myself.				
17. At times I think that I am no good at all.				

	Almost Always	Most of The time	Some of The time	Not at All
During the past week did you:				
18. Lack enthusiasm for anything ?				
19. Have a poor appetite ?				
20. Feel Lonely ?				
21.Feel Bored or have little interest in doing things				
22. Lose sexual interest or pleasure ?				
23. Have trouble getting sleep or staying asleep				
24. Cry easily or feel like crying ?				
25. Feel downhearted or blue ?				
26. Feel low in energy or slowed down ?				
27. Feel hopeless about the future ?				
28. Are you able to afford a home suitable for (yourself?family) ?				
29. Are you able to afford furniture or household equipment that needs to be replaced ?				
30. Are you able to afford the kind car you need				
31. Do you have enough money for the kind of food (you/your family) should have ?				

	Almost Always	Most of The time	Some of The time	Not at All
32. Do you have enough money for the kind of medical care (you/your family) should have ?				
33. Do you have enough money for the kind of clothing (you/your family) should have ?				
34. Do you have enough money for the type of leisure activity (you/your family) want (s) ?				

35. Do you have a great deal, some , a little or no difficulty paying your bills ?

36. At the end of the month do you end up with lots of money left over, some money left over, just enough to make ends meet, or not enough to make ends meet ?

Appendix E

Scaling Form Used to Record the Self-Anchored Rating Scale Question

SCALING FORM File # _____

From the time you called being 1, and 10 being where you want to get to...Where are you now ?

	FAMILY MEMBER INITIALS			
SESSION #	MOM	DAD	CHILD	CHILD
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				

Appendix F

Solution Focused Therapy Post-Intervention Telephone Follow-up Questionnaire

Solution Focused Therapy Telephone Follow-up

1. When you contacted Family Services you had identified your main concern as being _____.

    a) Is that concern for you now the same, better or worse ?

    b) Can you describe that to me ?

2. If you could think back to the time you first called Family Services, on a scale of one to ten with one being when you first initiated contact, and ten being the resolution of your problem, where are you now ?

3. Generally how have other areas of your life been going ?

    a) Is that better than expected, the same, or worse ?

4. Since last seen at Family Services Inc., have you needed to seek additional help ?

    a) If yes, can you tell me more about that ?

5. Have any new problems developed since you have finished at Family Services?

    a) Can you describe these problems ?

    b) Do you feel confident in handling these problems ?

6. Do any of these reasons for discontinuing at Family Services Inc. apply?

1. I met my goals, therapy was complete.	(Y)	(N)
2. I disliked the therapist.	(Y)	(N)
3. I could not afford it, the fees were too high.	(Y)	(N)
4. I did not seem to be getting anywhere.	(Y)	(N)
5. I had scheduling or transportation problems.	(Y)	(N)
6. My problems were not as bad as I thought.	(Y)	(N)
7. I felt I could get better help elsewhere.	(Y)	(N)
8. I did not like the team approach.	(Y)	(N)
9. Friends/relatives/partner put me down for seeking out help.	(Y)	(N)
10. I did not like the type of therapy that was used.	(Y)	(N)

7. What part of your therapy was most helpful ?

Appendix G

Consent to Participate in a Research Project

FAMILY SERVICES OF WINNIPEG UNIVERSITY OF MANITOBA SERVICE STUDY

Dear Sir/Madam,

We are currently in the process of evaluating our services and are seeking interested parties who would be willing to participate in this study. Adults interested in participating will be asked to complete a questionnaire pertaining to stress and coping, as well as one pertaining to the family as a whole. Children participating in the study will be given a questionnaire that addresses self-concept. These questionnaires will be given prior to being seen for counseling, and upon completion of the services received. One to three months after your counseling has ended we will contact you by phone to ask some questions pertaining to the services that you and your family have received. As part of the program evaluation we are video-taping the initial sessions in order to observe the therapist. The tapes will be treated as all of the information gathered, strictly confidential. All information will be used exclusively for research purposes and as part of a graduate studies thesis on the evaluation of Family Services.

Participation in this study is completely voluntary and you may withdraw at any time. Your participation or non-participation in the study will not influence the services that you receive.

I _____ consent to participate in the research study described above.

Date: _____ Signature _____

APPENDIX H

Brief Family Assessment Measure

	STRONGLY DISAGREE	DISAGREE	AGREE	STRONGLY AGREE
1. Family duties are fairly shared.	1	2	3	4
2. My family expects me to do more than my share.	1	2	3	4
3. We feel loved in our family.	1	2	3	4
4. When things aren't going well it takes too long to work them out	1	2	3	4
5. I never know what's going on in our family.	1	2	3	4
6. We deal with our problems even when they're serious.	1	2	3	4
7. When you do something wrong in our family, you don't know what to expect.	1	2	3	4
8. We tell each other about things that bother us.	1	2	3	4
9. It's hard to tell what the rules are in our family.	1	2	3	4
10. My family tries to run my life.	1	2	3	4
11. We take the time to listen to each other.	1	2	3	4
12. Punishments are fair in our family.	1	2	3	4
13. When someone in our family is upset, we don't know if they are angry, sad, scared, or what.	1	2	3	4
14. We are free to say what we think in our family.	1	2	3	4

JUN-22-1994 11:04 FROM BEHAVIOURAL SCIENCE TO 912047874975 P.002

University of Toronto
Faculty of Medicine

Department of Behavioural Science
McMurrich Building
Toronto, Ontario M5S 1A8
Phone (416) 978-8606
Fax (416) 978-2087

June 20 1994

DELIVERED BY FAX 204-787-4975

Sharlynne Burke

Dear Ms. Burke:

In response to your letter of June 13, 1994, you have my permission to duplicate the Brief FAM in your Master's Thesis report entitled "Examination of Solution Focused Therapy at Family Services of Winnipeg". I would be quite interested in receiving a report regarding your findings.

With all good wishes.

Sincerely,

Harvey A. Skinner, Ph.D.,
Professor and Chair
Telephone (416) 978-8989
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HAS:wk