A STAFF DEVELOPMENT PROGRAM: A TWO DAY WORKSHOP FOCUSING ON SOLUTION-FOCUSED THERAPY

by

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A Practicum Paper
Submitted to the Faculty of Graduate Studies
in Partial Fulfilment of the Requirements
for the Degree of

MASTER OF SOCIAL WORK

Department of Social Work
University of Manitoba
Winnipeg, Manitoba

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ISBN 0-315-92319-9

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

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ABSTRACT

This practicum paper gives a description of a staff development program. A two-day workshop focusing on solution-focused therapy was designed and presented to three groups of professionals: Family Services and Community Mental Health from Flin Flon and The Pas, Child and Family Services in Winnipeg and Vocational Rehabilitation in Winnipeg. The participation in the workshop was voluntary. Each participant was asked to evaluate the workshop. A participant feedback form, a participant satisfaction questionnaire and a follow-up interview with 15% of the participants from each group selected randomly comprised the evaluative component of this staff development program.

The workshop consisted of a lecture format which presented skills and tools about solution-focused therapy, experiential learning which involved role plays, group activities and discussions as well as taped case presentations.

The evaluation of the staff development workshop indicated a statistically significant improvement in attitudes and knowledge about solution-focused therapy after the workshop for all three groups. Each group found the workshop to be useful and informative. They also found that the facilitator had the ability to deliver a workshop. Based on the follow-up interviews, the participants were attempting to incorporate the skills learned into their present style of working. Time and motivation seemed to influence the application of the skills learned. Successes and struggles with the solution-focused model were expressed, and a brainstorming and sharing session with all participants from each respective group was viewed as the best form of follow-up.

ACKNOWLEDGEMENTS

This author would like to extend gratitude to Professor Joe Kuypers for the invaluable guidance and direction provided during the course of this practicum.

Special thanks are extended to Linda Campbell for the countless hours she provided in the evaluative section of this practicum.

Thanks are also extended to Sara Axelrod and Ken Atnikov for their recommendations and constructive criticism during the creation of the staff development package. Their words of wisdom kept the content accurate.

Thanks are also extended to the counselling staff of Family Centre of Winnipeg for their encouragement. Thanks also to the Family Centre of Winnipeg for allowing this practicum to be hosted from this agency.

Deep appreciation is also extended to the participants from The Pas, Child and Family Services and Vocational Rehabilitation who willingly participated in the workshop and in the completion of the evaluation.

Finally, grateful appreciation goes out to friends, family, and, in particular my partner, Robert, for their continuous support and encouragement throughout the past four years.

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CHAPTER ONE

INTRODUCTION

The objective of this practicum was to conduct an exercise in human resource development by developing a short-term staff development package focusing on solution-focused therapy. This author hoped to acquire the skills of developing and delivering a workshop to professionals in the helping field. In the process of developing the staff development workshop, skills and knowledge regarding solution-focused therapy would also be enhanced.

This human resource development activity consisted of a two day staff development workshop comprised of theory as well as of hands on experiential learning. This practicum included three phases: 1) designing the two day workshop; 2) delivery of the package; and, 3) follow-up interviews with 15% of the participants. In addition, measuring tools were designed and admininstered to participants in order to obtain background information in regards to the participants as well as information pertaining to the level of satisfaction and skills acquired via the workshop.

CHAPTER II

LITERATURE REVIEW

2.1 Introduction

This chapter will review the pertinent literature associated with the subject matter of this practicum: The creation of a staff development program comprised of a two day workshop focusing on solution-focused therapy.

The literature review will begin by broadly examining adult learning and human resource development. As the review begins to focus, staff development programs, including how to design and evaluate these programs will be explored. The literature review will conclude with an examination of the literature regarding solution-focused therapy.

2.2 ADULT EDUCATION AND ADULT LEARNING THEORY:

Jarvis (1983) argues that learning is a basic human need and the process of learning continues throughout one's life time: "Hence it is maintained that life-long education should be regarded both as a human right and as a fundamental necessity in any civilized society in order that every individual is enabled to respond to his learning needs, fulfil his potential and discover a place within the wider society" (p. 57).

Knowles (1977) identifies three different meanings to adult education. In its broadest sense, he describes the following process of learning:

> In this sense it encompasses practically all experiences of mature men and women that produce new knowledge, understanding, skills, attitudes, interests, or values. It is a process that is used by adults for their self-development, both alone and with others, and it is used by institutions of all kinds for the growth and development of their employees, members, and clients. (p. 52)

In its more technical sense, Knowles (1977) describes adult education as "a set of organized activities carried on by a wide variety of institutions for the accomplishment of specific educational objectives" (p. 52). Knowles includes in these activities, organized classes, study groups, lecture series, planned reading programs, guided discussions, conferences, institutes, workshops, exhibits, and correspondence courses.

Knowles (1977) describes a third meaning for adult education combining the two afore-mentioned definitions:

> In this sense, adult education brings together into a discrete social system all the individuals, institutions, and associations concerned with the education of adults and perceives them as working toward the common goals of improving the methods and materials of adult learning, extending the opportunities for adults to learn, and advancing the general level of our culture. (p. 52)

Furthermore, the literature on Continuing Education in Social Work encompasses specific and general programs such as upgrading of professional skills and knowledge or in-service training, continuing education to fulfil licensing requirements, and, preparation

for other professional levels of education (Doelfker, 1977, cited in Continuing Education in Social Work, Literature Review, prepared by Taylor, edited by Hutton). Gibelman and Humphreys (1979) suggest that often these programs are used interchangeably without mention as to how they are similar or different from one another. They suggest that a distinction between these terms is needed. Gibelman and Humphreys (1979) offer the following definitions:

> (1) in-service/staff development are programs designed to meet the learning needs of a specific staff within a particular organization.
>
> (2) professional development is a term used to refer to conferences, seminars, and other educational activities devoted to the development of professional competence...Such activities are often sponsored by professional associations and need not have immediate relevance to the performance of a particular job.
>
> (3) continuing education (in its specific meaning) has come to be thought of as synonymous with university-based programs. (p. 401)

Zimmerman (1978) concludes from different studies conducted to determine the reasons for which social workers participate in adult education programs, that "social workers attended to improve their professional competence, to gain intellectual stimulation from instructors and other professionals, and to pursue an interest in the conference topic. Very few persons responded that they participated to fulfil an assignment by their agency" (p. 114). Furthermore, Brenner and Koch (as cited in Zimmerman, 1978) found in their study, that often social service organizations offered incentives to their staff members to

participate in adult education programs which included, paid time away from work, payment for the continuing education program, travel, lodging and meals.

Brenner and Koch (1976) found that social services professionals were more interested in continuing their occupational learning, but want these programs to have direct relevance to practice. These professionals were interested in learning more about methods when dealing with problem clients and to gain more knowledge in their related discipline. Brenner and Koch (1976) found the following:

> Respondents expressed considerable preference for short-term programs sharply focused upon single or closely related topics. They also liked problem-oriented programs in which they sought solutions to real-life situations encountered in practice. They were not adverse, however, to traditional programs formats, such as lectures, panels, and symposia, or even traditional courses as they were relevant to practice. (p. 74)

Knowles (1984) summarizes that there are three groups of learning theories, each appropriately based on particular conditions. The first are mechanistic (or behaviourist) theories which claim that "if you introduce an input (stimulus) into a human being and control how that input is processed (operant conditioning), you will get a predetermined output (response)" (p. 6.6). Therefore, according to mechanistic theories, education's purpose is to obtain a prescribed behaviour which a teacher decides the learner should perform.

The second, cognitive theories, delineates human beings from other living forms by the fact that humans possess a brain and are capable of critical thinking and problem-solving. Learning will stimulate the brain into critical thinking and problem-solving exercises.

The third, organismic (or humanistic) theories, maintain that all living creatures have a predetermined, individual potential. Learning will allow for one's full potential to be developed.

Knowles (1978) says that given that adult learning is a new area for scientific investigation, much of what is known is based on assumptions rather than knowledge:

> I speculate, with growing support from research, that as individuals matures, his need and capacity to be self-directing, to utilize his experience in learning, to identify his own readiness to learn, and to organize his learning around life problems, increases steadily from infancy to pre-adolescence, and then increases rapidly during adolescence. (p. 54)

Among adult educators, andragogy, a theory of adult learning, is widely used. Knowles (1984) defines the term andragogy as deriving from the Greek word anere, meaning for adult , and agogus, meaning the art and science of helping students learn. "Andragogy, or adult learning theory, presents a learning model that centres on learners rather than instructions, making them active participants in the process" (Dastoor, 1993, p. 17).

Knowles (1984) identifies five assumptions made about adults as learners. Firstly, adult learners have a need to know. More specifically, adults learn better if they understand the reason for which they need to know or the purpose of their learning. When adults set out to learn something, they will explore the benefits of the learning versus the costs of not learning. In human resource development programs, the employees who decide to partake voluntarily in learning activities, will assess the gains and benefits for themselves. However, those employees who are involuntary participants may not understand or have assessed the benefits for themselves. Therefore, they will not be committed to the activity or may be resistant to learning. Hence, the possible benefits and gains acquired need to be emphasized and discussed with employees. Knowles (1984) suggests that the more directly an adult learner can experience the benefits, as opposed to only being told about them, the more strongly they will have the desire to know and to learn.

Secondly, adult learners have a need to be self-directing. Adults have the need to take responsibility for their own lives. In fact, adults have the need to be perceived and treated by others as being capable of taking responsibility for themselves. Whenever adults feel threatened by another person making decisions for them, a sense of resentment and resistance to the situation will be experienced. However, Knowles (1984) suggests that when adult learners enter into a learning activity, they seem to revert back to the perceived role of a student as a dependent role thus expecting the teacher to direct them. In order to assist adult learners to become more self-directing, Knowles (1984) proposes that an orientation be given. This orientation can be brief (a few hours) or extend over

many days. He suggests that the components of the orientation to self-directing learning are as follows: "1) an exposure to the idea that differentiate being taught from learning; 2) a relationship-building and resource identification exercise; and 3) some practice exercises to sharpen skills in self-directed learning" (Knowles, 1984, p. 6.9). At first, when adults are more responsible for their learning, they may experience some confusion, tension and anxiety. However, as they become more familiar with self-directing their learning, Knowles (1984) states that they will tend to invest more energy into their learning.

Thirdly, adults accumulate a great volume and quality of experience. Due to their ages, the things they have accomplished and the experiences acquired, when adults come together as a learning group they represent a very heterogeneous group. "Hence the emphasis in adult learning is on the individualization of instruction- the provision for a wide choice of learning strategies and resources and the extensive use of subgroups or networks linking people with similar backgrounds" (Knowles, 1984, p. 6.10). Adults are thus a rich source for learning both on an individual and group basis and this richness can provide a base on which to relate new learning. Knowles (1978) suggests that this is the reason for which, in adult learning, much emphasis is placed on experiential techniques that draw from the experiences of the learners and provides opportunities from which they can learn: "The use of lectures, canned audio-visual presentations and assigned reading tend to fade in favour of discussion, laboratory, simulation, field experience, team project, and other action-learning techniques" (p. 56).

Knowles (1978) suggests that there is another reason for emphasizing the utilization of the experience of the learner. Adults define who they are by their experiences. For a child, experience is something that happens to them whereas for adults, experience is who they are. Thus, if an adult's experience is being devalued, the adult perceives this as a rejection of him/ her as a person. "Andragogues convey their respect for people by making use of their experience as a resource for learning" (Knowles, 1978, p. 56).

Fourthly, adult learners have a readiness to learn based on what will bring them the most satisfaction or success in life. Knowles (1978) states that andragogy assumes that adult learners are ready to learn those things they need based on the developmental phases they are approaching. Involved in this concept is the element of timing. Learning opportunities which are timed with the learners readiness to learn and the tasks needing to be accomplished during a certain development phase will be effective than those for which the learners are not ready or unprepared. Knowles (1978) suggests that readiness to learn can be stimulated by exposing the learners to better models of performance, higher levels of aspiration and self-directing procedures.

Fifthly, adult learners have a life-centred, task-centred, or problem-centred orientation to learning. Adults see the purpose for learning as building skills that will enable them to cope more effectively with life, perform required tasks and aid in problem-solving. According to Tough (1981) adults participate in learning activities due to a fairly immediate problem, task or decision that demands certain knowledge or skill. An adult's

time perspective is one of immediacy of application; what is learned today can be applied tomorrow.

Knowles (1978) states that the andragogical model is a process model in comparison to the content models used by most traditional educators. Knowles (1978) describes the difference. In traditional education the teacher or trainer decides in advance what knowledge or skill needs to be transmitted, prepares the content to be presented, decides on the most efficient means for transmitting this content (lectures, readings, films, tapes, etc.), and then develops a plan for presenting the content. In andragogical learning, the teacher is a facilitator who prepares a set of procedures for involving the learners. Knowles (1978) suggests that this process involves these elements:

> (1) establishing a climate conducive to learning; (2) creating a mechanism for mutual planning; (3) diagnosing the needs for learning; (4) formulating program objectives (which is content) that will satisfy these needs; (5) designing a pattern of learning experiences; (6) conducting these learning experiences with suitable techniques and materials; and (7) evaluating the learning outcomes and rediagnosing learning needs. (p. 108)

The traditional education model, is more concerned with transmitting information and skills whereas the andragogical model is concerned with providing procedures and resources for helping the learners acquire information and skills. Reed (1993) suggests that at times a more teacher-directed approach may be necessary for teaching adults, especially in an area in which the learner has little or no experience.

Knowles (1984) contends that the physical and psychological climates are very conducive to learning. In regards to the former, Knowles (1984) encourages that chairs be placed in a circle around tables to encourage active participation. Other important considerations are room temperature, ventilation, easy access to restrooms, breaks, comfortable chairs, adequate lighting, good acoustics and resource material such as books, pamphlets, manuals and audio-visual aids.

The psychological climate is even more important to learning than the physical climate. Knowles (1984) and Reed (1993) identify the following characteristics which they view as being conducive to learning:

1) Encourage a climate of mutual respect. Having participants write their names on a card can foster an atmosphere of respect. Also asking participants to talk about themselves by identifying who they are, what special qualities they bring to the group, and, what they would like to get out of their learning experience (goals, questions, problems or concerns) encourages an atmosphere of respect.

2) Encourage a climate of collaboration as opposed to competiveness. Adult learners need to be encouraged to share and view their experiences and knowledge as a rich resource for learning.

3) Encourage a climate of supportiveness. All contributions are accepted as being significant and worthwhile contributions.

4) Encourage a climate of mutual trust. In order to convey a trusting environment, the educator needs to do away with the power and authority role and replace

it with the role of facilitator or helper. The facilitator should also actively behave in ways to convey trust.

5) Encourage a climate of active inquiry. The adult learner actively participates by volunteering information or sharing concerns.

6) Encourage a climate of openness. The facilitator and learners are encouraged to be open, natural and authentic.

7) Encourage a climate where a relaxed environment can exist. Leave time for participation and practice.

In addition to the physical and psychological climate, Knowles (1984) believes that the organizational climate will also affect learning. The way in which an organization will support human resource development programs and encourage employees to participate is a contributing factor. Managers' style, either controlling or facilitating, and/or structure of the organization will affect employees willingness and self-motivation to learn. Availability of financial resources will also impact on the accessibility to educational programs. Lastly, organizations prepared to give employees rewards for their efforts in learning can stimulate motivation in learning.

2.3 HUMAN RESOURCE DEVELOPMENT:

The definition for human resource development was first introduced in 1968 by Leonard Nadler and continues to be operational today. Nadler and Nadler (1989) defines human resource development as: "1. organized learning experiences provided by

employers, 2. within a specific period of time , and, 3. to bring about the possibility of performance improvement and/or personal growth" (p. 6).

The first concept of organized learning experience suggests that the learning is intentional rather than incidental. We are in a constant process of learning. Incidental learning represents the things we do on a daily basis which we learn but had no intention of learning. In human resource development, "the focus is on intentional or purposeful learning, when the learner is engaging in the experience with the express intention of learning" (Nadler and Nadler, 1989, p. 10).

The second concept, within a specific period of time, speaks to the duration of a human resource development activity. The duration may range from one hour to one year. Nadler (1989) suggests that whatever the length, it should be clearly specified so there is no confusion as to when it will start and when it is scheduled to end. Given that human resource development is often conducted during working hours, this specification is necessary. Furthermore, Nadler and Nadler (1989), states that duration effects on the evaluation: "It is possible to evaluate learning at different times during an human resource development program, but it is essential to evaluate at the completion of the program" (p. 11).

The third concept, which entails bringing about possibility of performance improvement and/or personal growth, implies that learning can take place without producing any performance improvement. However the possibility of improved performance can be increased by implementing support systems for the learner following the program. Nadler and Nadler (1989) define performance improvement as "how

individuals do their jobs individually or in relation to others after the human resource development experience" (p. 12). Furthermore, Nadler (1984) says that the concept of growth encompasses the elements of growth within the organization and within oneself. The former suggests that employers can provide learning that will allow the individual to grow with an organization. There is recognition that change is constant and that learning can help individuals keep up with the changes in the workplace. Personal growth entails a number of learning that will allow individuals to achieve inner satisfaction which can be either job or non-job-related.

Human resource development comprises three different activities which are often used synonymously: training, education and development. However, Nadler (1984) makes a distinction between these activities:

> Training is learning related to the present job; the learning is for improved performance on the present job of the individual. Education is learning to prepare the individual for a different but identified job in the not-too-distant future. Development is learning for growth of the individual but not related to a present or future job. (p. 1.16)

The important distinction between training and development is "that development is not job related. As with other learning, this does not mean that what is learned during development cannot be applied to a present or future job. It is not the essential purpose" (Nadler, 1984, p. 1.22).

2.4 STAFF DEVELOPMENT: A LEARNING ACTIVITY:

A closer look at staff development is important to further define the activity undertaken in this practicum. As previously mentioned, the purpose for staff development is to benefit both organizations and individuals, but they do not have to be mutually exclusive (Nadler and Nadler, 1989). With the changes in present society, organizations are asked to keep up with the changes and the demands from the work force. When employees and employers are ready and open to learning new skills in order to keep up with changes and demands, it seems much easier to move a workplace in the direction of the new trends. Staff development is an activity that may keep the workplace in a learning mode (Nadler and Nadler, 1989).

Staff development is sometimes referred to as an activity designed to release human potential. Nadler and Nadler (1989) state that "development provides opportunity for people to move in uncharted directions" (p. 77). Development can be more of a risk taking endeavour, for its objective is concerned with the person's learning rather than with how the person will use this learning, as is the case in education or training activities. However, skills developed through staff development can be put to use for the benefit of an organization or agency.

Additional staff development objectives have been identified by Leonard (1974, as cited in Austin et al., 1984) and they include the following:

(1) orienting new employees; (2) identifying worker performance deficiencies; (3) coping with legal, societal, economic, and technological changes so that the organizations can flexibly meet emerging needs and unexpected contingencies; (4)

preparing and upgrading employees for more skilled positions and possible advancements; and (5) enabling employees to keep up with current developments in their field of specialization. (p. 81)

Furthermore, Miller and Verduin (1979) define staff development as follows:

a learning program concerned with staff members who are associated with and employed by an organization. It is an organizationally sponsored learning effort which is based upon staff members' previous learning and job experiences, and the organizational needs, mission, and goals. The content of a staff development program is determined to a great extent by the social and economic needs of the organization. (p. 4)

Nadler and Nadler (1989), suggests that the responsibility for staff development rests at the management levels. Given that training and education are based on job performances, their needs are much more identifiable than those of staff development. If agencies and organizations do not view this activity as being an important part of the workplace, it is often unavailable to individuals.

Although management is responsible for staff development policy within their organization or agency, the implementation of a staff development activity can be provided by agency staff or by outside resources (Nadler and Nadler, 1989). Individuals from every level of the organization or agency can attend a development activity. Given this diverse representation, employees can interact and acquaint themselves with

colleagues on an informal basis. Selection for development activities needs to be voluntary or self-selected, for not all employees are interested in development opportunities. "No employee should be coerced, either overtly or covertly, to take part in staff development. That would defeat the purpose and would prove to be counterproductive" (Nadler and Nadler, 1989, p 79).

2.5 DESIGNING LEARNING PROGRAMS:

As previously mentioned, human resource development is concerned with intentional learning. Wiggs (1984) best defines learning as "a process of internalizing skills, knowledge, or attitudes which provide a relatively permanent change in behaviour" (p. 7.4). Change is the most important component of learning. The change which takes place can result in very obvious behaviour changes or covert behaviours which are not seen externally.

Staff development programs need not be scheduled into a structured course or curricula like in other types of learning. Miller and Verduin (1979) identify three types of learning structures: informal, nonformal and formal learning. They believe that "a good staff development program would use all three forms as well as combinations of each as is best determined by the success of the staff development program" (Miller and Verduin, 1979, p. 73).

An informal learning program is directed at self-improvement. Miller and Verduin (1979) suggest that this program relies on staff members to develop and implement means for learning. Furthermore, it requires that the responsibility for choosing a learning goal,

selecting a learning strategy, executing that strategy, evaluating the outcome and communicating the results rests upon staff members.

A nonformal learning program emphasizes group activities. Each member is responsible for the functioning of the group. Miller and Verduin (1979) suggest that it allows for programming dealing with needs of the individuals and the organization, learning of specific skills and knowledge whether needed, demanded or desired, and, a population which can be easily subgrouped according to learning opportunities and needs. In regards to staff development, nonformal learning is a useful approach given that it is very flexible and unstructured. "Whether programs are of short or long duration, for single or multiple sessions, and for direct or indirect job performance, this approach tends to be flexible and practical in its orientation" (Miller and Verduin, 1979, p. 81). Furthermore, nonformal learning tends to focus on participants being involved in the programming which includes, "workshop, sharing of practices and techniques, and small group activities" (Miller and Verduin, 1979, p. 81). Nonformal learning emphasis is on peer teaching or adults teaching adults.

Formal learning is very structured and usually time specific. The content and presentation of the material are predetermined and prepared prior to the delivery of the program. Participants are required to conform to the program. Miller and Verduin (1979), suggests that pre-and-post tests can be used to determine the amount of knowledge prior to and following the program. "Formal learning provides a standardized program of studies for everyone and limits program distortions, misinformation, and duplication of effort" (Miller and Verduin, 1979, p. 84).

Wiggs (1984) states that learning program design models aid the designer in ensuring that learners will achieve their learning intent. There does not exist a perfect design model for all learning programs. "More often, the many variables involved in designing learning programs cause far less than ideal conditions to prevail. And yet, a learning program is designed, the program is implemented, and learning intents are accomplished" (Wiggs, 1984, p. 7.8). However this does not deny the validity of the designs and their contribution towards guidance and direction in accomplishing an effective learning program.

Wiggs (1984) maintains that every learning program has the following interrelated variables: objectives, learners, instructional materials or aids, program sponsors, content, instructional strategies, learning facilities or aids, and instructors/instructional media. Wiggs (1984) further maintains that most often a learning program will also have independent variables that must be considered, even though the designer may have little or no control over them. The following independent variables may impact on the program or its learners: organizational climate, reduction in force/layoffs, wage/salary issues, workflow problem, employee-supervisor conflicts, and technological changes.

Wiggs (1984) identifies two forms of design models. The first design is descriptive in nature. In this model, the designer describes the many variables to be considered during the design process. The designer is not required to follow a given sequence of steps, but should keep in mind the interacting variables associated with the learning program throughout its design, execution and conclusion. In a descriptive design model, data collection or analysis concerning the learner in the learning program design

process is not necessary, especially if the designer already knows the learners' needs. A descriptive model is an open systems design model which refers to the options the designer has in implementing the design process without needing to follow a step by step procedure.

The second design is prescriptive in nature. In this model, the designer follows prescribed step-by-step procedures in implementing the learning program. The designer using a prescriptive design model must check the learners' needs prior to building the curriculum content. Therefore, the designer must complete each and every step in sequence; there is no room for modification or adaptation in the model. Hence, a prescriptive model is a closed system giving the designer no option but to follow each and every step prescribed in the model.

The advantages of both the closed and open design models for learning programs have been identified by Wiggs (1984): (1) learning is job centred for it focuses on defined, specific job task or skills, knowledge, and/or attitudes; (2) clearly stated objectives are part of learning programs; (3) learners are given instructions stemming from a carefully designed curricula. The instruction is based on the needs of the learner and/ or agency. The instructional objectives will determine the material and methods used to transmit the instructional information; (4) given that learning programs are geared for the learner to increase skills, knowledge and/or attitudes, there is greater possibility for learner participation and motivation; (5) efficiency of learning is encouraged by maximizing learning during the program design by prioritizing the areas which the learners should and must know; (6) instructors can focus on learning facilitation in order

to make the learning much more effective and efficient by knowing that the instructional material will be helpful in the delivery of the information. Wiggs (1984) concludes that:

> an open system model permits the elimination of certain steps in the design process when the needs assessment or some other step has already been accomplished and is furnished to the designer. By far, the majority of designers follow an open systems design model, for obvious reasons. (p. 7.11)

Wiggs (1984) suggests that in order to design an effective and efficient learning program a number of tasks are needed: 1) determine appropriateness of a potential learning program; 2) conduct needs assessment; 3) identify learners' needs, including such data as anticipated number of learners, location of the learners, working background of the learners, motivations of learners, specific interests or biases of learners, job performance requirements (just to name a few), in order to aid in the decision making concerning the proposed learning program; 4) analyze characteristics of the learners' jobs and tasks; 5) establish the overall learning program objectives, the general instructional objectives and the specific learner objectives for the learning program which will reflect learners' needs and describe the learning intents of the program; 6) write a statement of learners' objectives which will comprise of a description of tasks, conditions and standards under which performance can be observed; 7) create course, learning package and workshop by determining components of the learning program, always keeping in mind the learning intent; 8) organize the learning content into a meaningful instructional sequence; 9) specify instructional strategies; 10) identify

learner activities; 11) determine instructional resources appropriate for the delivery of the instructional activities; 12) determine the size of the learning group, the learning environment, the duration of the program, costs and number of facilitators; 13) communicate the instructional activity effectively to the learners by conducting the learning program; 14) evaluate the learning package.

As indicated, when designing a learning program, it is mandatory to identify learner performance objectives. Given their importance, a further exploration of objectives will follow. Wiggs (1984) identifies different types of objectives and they include the following: 1) behavioral terminal objectives which includes a specific statement of what will be expected of the learner at the conclusion of the learning experience; 2) nonbehavioural terminal objectives which describes the expected learning outcomes by the learner but not in behavioral terms; 3) organizational improvement objectives which reflect the desired results of the learning experience for an organization; 4) ultimate value objectives focuses on the anticipated and final results. Learning objectives are comprised of a statement of intentions and a description of what the learner will be doing when demonstrating achievement of the objective.

Austin et al. (1984) state that developing learning objectives involves six steps: 1) selection of tasks developed by a trainer or from existing tasks; 2) formulation of specific behavioral objectives that relates to the goals; 3) identification of the level of training to be conducted; 4) selection of procedures addressing the issue of what the learner needs to be able to do or know; 5) formulation of subobjectives specifying what the learner must know or be able to do before performing or completing the behaviour

objective; and 6) identification of the methods used to achieve the behavioral objectives such as through role play, lectures, presentation etc..

Furthermore, when Knowles (1972) designs learning activities, he takes into account that adult learning is a process of self-directed inquiry. He thus employs a process design containing seven elements:

1. Setting a climate. Creating a climate that is conducive to learning is very important to the quality of learning. Knowles (1972) states that he attempts to achieve a climate of informality, mutual respect, collaboration, openness, authenticity, trust, nondefensiveness, physical comfort, and curiosity.

2. Mutual planning. It is important to have participants involved in some way in the planning of the program. Knowles (1972) explains that "any person tends to feel committed to any decision or activity to the extent that he feels he has influenced the decision or activity" (p. 38).

3. Diagnosing needs. This can be accomplished by asking individuals themselves what they want or what they think they need to learn in order to be more productive. In a group context, learning needs may be identified as a group. Another approach in diagnosing the needs of the learning involves two steps: 1) creating a model of competency required for performing a given role adequately; and 2) asking learners to assess their present level of development on this competency model.

4. Formulating program objectives. Knowles (1984) states that "the purpose of program objectives is to provide program planners with some guidelines as to broad goals for which they will be held accountable and to provide consumers with a basis for

selecting those aspects of the program that would be relevant to them" (p. 6.18). He further says that the objectives can be described in a terminal behaviour terms which can be observed and measured or described in terms of directions of growth, encompassing knowledge, skills, attitudes and values.

5. Planning a sequential design of learning activities. This involves arranging the units of learning in a manner of continuity, sequence and unity.

6. Conducting the learning experience. This component is concerned with the execution of the learning experience.

7. Evaluating the learning. Knowles (1972) advocates for less thinking in terms of evaluating and more in terms of rediagnosing the assessment of the outcomes of the learning. Rediagnosing involves asking learners to reexamine their level of development. This approach sways away from the traditional technique of pretest and posttest. "It requires such qualitative techniques as participant observation, in-depth interviews, case studies, personal diaries, analyses of performance changes, and others" (Knowles, 1984, p. 6.22).

Jorgensen and Klepinger (1979) suggest that trainers must be able to plan, design, facilitate and evaluate. They must care for, respect and trust the participants. They must create an environment where the participants can utilize tools, self and others to develop knowledge, attitudes and skills. Furthermore, Rothman (1973), identifies different typologies of teaching strategies from which trainers can select: (1) teacher as an expert, (2) teacher as a form of authority, (3) teacher as a socializing agent, (4) teacher as a facilitator and (5) teacher as a person. Rothman (1973) suggests that the teacher as the

facilitator is the most useful mode in adult learning. A facilitator supports independence, makes provision for divergent thinking, allows participants to proceed at their own pace of learning and enhances motivation in learning. The teacher as a person encourages adult learning.

2.6 EVALUATION OF LEARNING PROGRAMS:

Individuals involved in staff development are faced with two major questions when implementing and evaluating program (Austin et al., 1984). Firstly, did the staff development program meet its objectives? Secondly, how has the program influenced participants?

Chabotar and Lad (as cited in Austin et al., 1984) and Philips (1984) suggest that there are five reasons for which staff development evaluation is important. The first reason is the need to determine if the objectives were met in the form of improved staff competencies measured by the amount of change in workers' attitudes, knowledge or skills. The second reason for evaluation is to identify the strengths and weaknesses of the program so that the quality can be maintained or improved through changes in the method of presentation, educational tools, setting and other instructional methods. The third reason is to determine the relationship between staff development cost and possible benefits to the agency or organization. The fourth reason is related to the need to justify continued staff development programs in the future by using outcome data. The fifth reason is to provide data that will be useful in assessing the results of specific programming and in determining the needs for additional training or development. Philips

(1984) identifies a sixth reason for evaluation. He states that evaluations can reinforce the information covered in the program.

The literature recommends a pre/post/then approach when evaluating learning for social work staff (Doueck, Bondanza, 1990; Austin et al., 1984). The pre/post/then technique consists of participants completing a pretest and posttest. Following the training and completion of the posttest, participants will be asked to reflect back on their knowledge and skill level at the start of the training. Doueck and Bondanza (1990) state the following in regards to this form of testing:

> It is common for participants to overestimate their skills and knowledge at the beginning of a training program and to realize how much they did not know or could not do at the conclusion of the program. As a result of this response-shift bias, a pretest posttest method may fail to reflect any improvements which may have occurred in a participant's skills or knowledge base. (p.124)

Once this shift in perspective has been accomplished the participants will be given a second posttest to complete which will be the "then" test. Doueck and Bondanza (1990) indicate that these "then" scores allow for more accurate assessment of pre-training skills as these scores are obtained at the conclusion of the training when it is presumed that the participants have a knowledge of the concepts and skills that were to be learned.

When designing and administering testing, Philips (1984) recommends the following guidelines. Firstly, select the appropriate type of questions. Questions can be open-ended, eliciting an unlimited answer, checklist format which lists items and directs

the learner to check those which apply, two-way which have alternate responses, multiple-choice which gives the learner many options to chose from and the ranking scale which requires the learner to rank a list of items.

Secondly, the test should allow the learner to demonstrate the skills and knowledge gained from the program.

Thirdly, every step of the test should be planned including the timing of the test, preparation of the learner, administration of the test and the evaluation of the results.

Fourthly, all learners should be given the same directions as to the execution of the testing because the quality of the directions can influence the outcome of a test.

Fifthly, predetermined standards of the test need to be developed so that the learner will know in advance what is expected for the satisfactory completion of the test.

Sixthly, the test should not include any trick questions that will cause the learner to go astray when answering the test.

Learner feedback is another form of evaluation which is popular and frequently used but viewed as being less reliable than testing (Philips, 1984). Feedback requested from learners may focus on the following: Program content, instructional materials, method of presentation, the facilitator, planned improvements and the facilities to name a few.

Philips (1984) also identifies follow-up as another form of evaluation. The follow-up is conducted at a predetermined time after the completion of the program. The purposes of the follow-up is as follows: to help measure the lasting results of the program, to emphasize areas where the learners show the most improvement, and, to

compare the responses at follow-up with those at the end of the program (Philips, 1984).

Philips (1984) identifies a few guidelines that will enhance the effectiveness of a follow-up evaluation: (1) determine the progress that the learner has made since the completion of the program; (2) ask as many of the same or similar questions as asked at the end of the program, for, this will allow for continuity of the data collected; (3) solicit from the learner any obstacles or reasons for which improvements may be lacking or negative comments shared; (4) the learner should be aware and expect a follow-up by communicating during the program or preferably at the end the intentions for a follow-up.

2.7 SOLUTION- FOCUSED THERAPY:

For a number of years, helpers using a brief model of intervention in therapy have been exploring new and innovative ways of dealing with complaints. Notably, Steve de Shazer, Insoo Kim Berg and their colleagues from the Milwaukee team developed an approach which is less problem focused and more solution oriented (de Shazer, 1985). The importance is on "exceptions" and "progress" rather than on "problems". Many clinicians, including de Shazer (1985, 1988), Berg (1990, 1991), O'Hanlon and Wiener-Davis (1989), Walter and Peller (1992) and others have developed their own version of solution-focused therapy based on their clinical backgrounds and orientation. The following assumptions or philosophy seem to be common to solution-focused therapists:

1) It is important to utilize what the client brings to therapy. Clients know what is best. They are experts about their problems and lives and have the resources to solve their problem.

2) It is not necessary to have detailed knowledge about the complaint in order to resolve it.

3) It is not necessary to know the cause or function of a complaint in order to resolve it.

4) Cooperation is necessary and mandatory. The notion of resistance does not exist.

5) All parts of the system are interconnected and interrelated.

6) A small change in a system may lead to bigger changes. Therefore, a big problem does not necessitate a big solution. Small changes are needed and will ripple to create other changes.

7) There are many ways of looking at a situation, none more correct than others.

8) Clients define their own goals, but they can also be co-defined with the therapist.

9) Change is constant and inevitable.

10) It is easier to build on success than it is to stop an undesirable behaviour. Pay attention to when the problem is not a problem. If it works, don't fix it; in fact do more of it. When it does not work, do something different.

Based on the afore-mentioned assumptions, influences from different theories can be noticed. Solution-focused therapy is a model of intervention which has been strongly

influenced by family therapy theories (Berg, 1991). In particular it has borrowed from the works of Bateson, Milton Erickson and the Mental Health Institute (de Shazer, 1985). Doherty and Baptiste, Jr. (1993) state that family therapy theories are interested in the examination of family interaction patterns. Berg (1991) notes that by changing the locus of the problem from the individual to the interactional system, the family became both the unit of observation and the unit of treatment. Doherty and Baptiste, Jr. (1993) state that Bateson was very intrigued with social interaction with its focus upon messages and communication. Bateson was also very interested in "the difference which makes the difference or an idea that is the news of difference" (de Shazer, 1982, p. 73). Solution-focused therapy pays close attention to exceptions to the problem or when a difference can make a difference. Bateson's notion that ideas develop from having two or more descriptions of the same process, pattern or sequence that are coded or collected differently helped to create the assumption that there are no right or wrongs in solution-focused therapy but only differences which are useful and creative (de Shazer, 1985). This was the creation of a poly-ocular view to situations (de Shazer, 1985).

Doherty and Baptiste, Jr. (1993) state that in the 1980's the ideas of constructivism permeated into family therapy theory. This concept "emphasized that what is real cannot be assessed objectively but only through the constructs of the observer, and reflexivity, which emphasizes that the observer is part of the system being observed" (Doherty and Baptiste Jr., 1993, p. 511). Constructivism's emphasis is on context and meaning. "Everything said is said from a tradition and has meaning only within that tradition" (Efran, Lukens and Lukens, 1988, p. 28). The constructivist will have an active role to

play in creating a view of the world and interpreting observations in terms of it (Efran, Lukens and Lukens, 1988). This author believes that the concept of constructivism takes roots from symbolic interactionism theory. The focus of this theory is on the connection between symbols and interactions. "It essentially is a frame of reference for understanding how humans, in concert with one another, create symbolic worlds and how these worlds, in turn, shape human behaviour" (LaRossa and Reitzes, 1993, p. 136). Similarly to constructivism, symbolic interactionism deals with the importance of meanings for human behaviour (LaRossa and Reitzes, 1993). Symbolic interactionism assumes that people will act based on the meaning given to a situation and that meanings come about as a result of interactions between people.

Solution-focused therapy is an interactive process that involves the client(s), therapist(s), and the context in which they work together. According to Walter and Peller (1992) "therapy becomes an interactional or joint experience, with problems and goals constructed or negotiated between client and therapist" (p. 6). Clients will often come into therapy presenting their problems in such a way that the difficulties are viewed as a fact of life or an unchangeable steady state. However, when asked, clients can describe when the problem does not exist. For the client this is not a difference that can make a difference. It becomes the role of the therapist to deconstruct these misperceptions and co-create a new meaning upon which solutions can built. Deconstruction (de Shazer, 1988) involves the therapist's accepting the client's frame as logical up to the point where it produces troublesome behaviour, thoughts, feelings and perceptions. It also involves

exploring the client's situation, sometimes in great detail and at great length looking for exceptions and promoting whatever is useful and helpful to the client.

de Shazer (1991) states that solution-focused therapy was greatly influenced by the works of Watzlawick on reframing, and the Brief Therapy Centre at Mental Health Research Institute (MRI). Reframing changes the client's viewpoint by placing it in another frame which fits the same situation equally well or even better, thus changing the entire meaning. The effect of this repositioning causes changes in behaviours, perceptions, emotional states and beliefs. Once the clients can see things differently, they can begin to behave differently.

The MRI view on brief family therapy caused this group to begin to sway away from the family therapy theory's belief that clients' problems as being a reflection of a dysfunctional social organization within the family (de Shazer, 1991). They began to look at the interactional patterns and the here-and-now of the therapeutic process as important rather than looking at causal explanations for complaints. The intervention was geared around behavioral changes described by the client as being problematic. They began the brief therapy notion that no matter how complex the situation, a small change in one person's behaviour can make a profound difference in the behaviour of all persons involved (de Shazer, 1985). In the MRI brief therapy model, the therapist along with the client, works out the definition of the therapeutic goals. MRI began to shift the boundaries (de Shazer, 1991) from the "client-plus-problem" to the "client-plus-problem-plus-therapist". Solution-focused therapists went one step further and redefined the unit of analysis as involving "client-plus-therapist-plus-goal" or solution. de Shazer (1991)

believes that "solution-focused therapy is seen as a mutual endeavour involving therapists and clients together constructing a mutually agreed upon goal" (p. 57).

Berg (1991) states that solution-focused therapists find it more profitable and easier to construct solutions than to dissolve problems. She goes on to say that it is simpler for clients to repeat successful behaviour patterns than it is to try to stop or change symptomatic behaviour. Both client and therapist are actively involved in exposing pre-session changes, which are positive changes that occur prior to therapy but since they contacted an agency for service. They also seek for the exceptions to the problem or periods when the expected problem does not occur. Whenever successful behaviours cannot be found, imagined solutions are sought by asking the miracle question and asking questions that will help the client to discover his/her own solution. Berg (1991) explains that the miracle question is a goal setting and solution finding technique which helps the client specify how things will be different once the problem is solved. Berg (1991) indicates that clients are asked the following question:

> Suppose there is a miracle tonight while you are sleeping and the problem that brought you here are solved. Since you are sleeping, you do not know that the miracle has happened. What do you suppose you will notice that's different the next morning that will let you know that there has been a miracle overnight. (p. 14)

Milton Erickson had an impact upon brief family therapists and solution-focused therapy. Erickson's notion of balance-theoretical maps helped solution-focused therapists

use the same map for both solutions and complaints (de Shazer, 1985). Symptoms or complaints are accepted and rather than trying to eliminate them, they are transformed into part of the solution. Furthermore, Erickson's confusion technique (de Shazer, 1985) was also adjusted to solution-focused therapy. It involves exploring in detail each point of difference between two or more people without any attempts at closure or resolution and then openly admitting one's bewilderment in regards to their differences (de Shazer, 1985). This technique allowed for a new construction of meaning and goal setting between the therapist and the client.

Erickson's questioning of resistance contributed to the development of the concept of co-operation (O'Hanlon & Weiner-Davis, 1989). Clients' non-compliance is viewed as their way of educating the therapist in regards to the methods that will work for them.

Erickson's contribution to hypnosis is also used in solution-focused therapy. Although clients are not put into a trance, they are asked future oriented questions which presuppose change. The therapist's use of language also presupposes change and the miracle question takes the client into the future (O'Hanlon and Wiener-Davis, 1989).

Solution-focused therapy has also borrowed from systems theory. It assumes that all parts are interconnected and interrelated. Whitchurch and Constantine (1993) suggest that one concept of systems theory is interdependence/mutual influence. They suggests that "because components in a system are interdependent, or held together in a system, behaviours of the components exhibit mutual influence, meaning that what happens with one component generally affects every other component" (Whitchurch and Constantine, 1993, p. 332). Solution-focused therapy also assumes that minimal change

is needed to begin solving complaints and that once the change is initiated, further changes will be generated by the client.

Solution-focused therapy also shares the systems theory concept of equifinality. Whitchurch and Constantine (1993) define equifinality as the system's ability to attain the same goals but through different routes. Solution-focused therapy believes that there are many ways of viewing a situation, none more correct than others.

Solution-focused therapy tends to give importance to the systemic concept of wholism (de Shazer, 1985). Whitchurch and Constantine (1993) state that the concept of wholeness is characteristic of systems because behaviours will emerge from specific arrangements in a system and from the transactions among parts made possible only by the arrangement. Therefore, the whole is greater than the sum of its parts. In solution-focused therapy, since interactive patterns can be seen as both individual and systemic habits all it would take is for one person to behave differently to break the habit (de Shazer, 1985).

Unlike systems theory, solution-focused therapy does not believe that the family unit will respond to change in a way to maintain a homeostatic balance and maintain its boundary. Berg (1991) states that solution-focused therapy views change as inevitable and constantly occurring.

This author believes that feminist theory has to some extent influenced solution-focused therapy. Osmond and Thorne (1993) state that feminism begins by assuming the centrality, normality, and value of women's experience. Solution-focused therapy finds it important to view the clients as experts in regards to their situation. The notion of

empowerment of clients is central to solution-focused therapy. Berg (1991) describes the following features used in empowering: 1) the client-worker relationship is a collaborative venture; 2) it is assumed that the client is competent to know what is good for them and their family; 3) it assumes that the client has the ability to solve problems and has done so in the past; 4) the clients negotiate their goals for therapy; and, 5) it is an approach that respects clients' autonomy and personal, familial and cultural boundaries, and, is less intrusive. Osmond and Thorne (1993) further explain that feminist theory is very centred around gender biases and the inequality in power and control based on gender. This author believes that solution-focused therapy has its shortcomings in addressing the political issues surrounding gender differences and the inequality in the distribution of power between the genders. Explanations for boundary violations through the use of violence or abuse are not given.

2.8 SUMMARY:

This author considered the definition of professional or staff development as the activity pursued through a two-day workshop. The staff development activity undertaken for this practicum was initiated by this author along with representatives from each of the three groups expected to partake in this activity.

In designing the workshop package, this author used the fourteen tasks described by Wiggs. Given that the needs of the participants were determined prior to the creation of the learning package, an open design model was used. The objectives for the two-day workshop were determined by this author and they were shared with the participants prior

to the activity. Each participant had the opportunity to determine for themselves whether they had the desire to partake in such a staff development activity.

In creating the workshop package, the objectives and goals were constantly referred to. The material was organized and presented in such a way to maximize upon the participants' learning. As Doueck and Bondanza recommended, a posttest consisting of a "pre" and "then" test was designed to evaluate knowledge and attitudes at the conclusion of the activity. A satisfaction questionnaire as well as follow-up interviews were designed by using the guidelines described by Philips.

In the delivery of the workshop and in its creation, the information pertaining to adult learning was referred to. Knowles concepts of self-directed learning, the richness of adults' experiences, readiness to learn and adults' life-centred orientation to learning were all anchors when designing this activity. The instructor in the role of facilitator was also recognized and incorporated into the delivery of the workshop. Knowles' recommendations in regards to the physical, psychological and organizational climate conducive to learning were all considered for this workshop.

CHAPTER III

THE PRACTICUM REPORT

3.1 Introduction

This chapter describes the staff development activity developed for this practicum. This practicum is a human resource development program which, through the use of a staff development activity, professionals working in the human services field were given the opportunity to enhance professional knowledge in the area of solution-focused therapy. The staff development may or may not have immediate relevance to the performance of a particular job but it was hoped that the tools presented would be utilized along with the existing skills possessed by workers.

3.2 Description of the Practicum

This practicum consisted of the delivery of a staff development program to professionals already working in the human services field. The program involved a two day presentation of a solution-focused approach, via a workshop format. It is important to note that this presentation took into account different styles of solution-focused therapy which this author reviewed as well as the skills developed through this author's professional experience. Hence, the training was not a presentation of one particular model but an integration of a number of styles (de Shazer,1985, 1988; Berg,1991;

Michelle Weiner-Davis and William O'Hanlon, 1986; Ben Furman and Tapani Ahola, 1992; Walter and Peller, 1992; and Huber and Backlund, 1991).

Three groups of professionals from three different disciplines received the training: Mental Health, Child and Family Services and Vocational Rehabilitation. The setting for the workshops varied from group to group. The workshop for the Mental Health professionals was delivered in the board room in the Provincial Building in The Pas, Manitoba. The workshop for the Child and Family Services Professionals was delivered in the board room of the Directorate office for Child and Family Services in Winnipeg. The workshop for the Vocational Rehabilitation professionals was delivered in the board room at the CNIB in Winnipeg.

This practicum incorporated the three types of learning structures: formal, nonformal and informal. The overall structure was formal, in that the program was designed prior to its delivery and an evaluative component was also included. It was also nonformal in that the program consisted of a workshop format. The emphasis of the learning was on peer teaching in a small group setting. Participants had the opportunity to share experiences and experiment with new and old techniques in the presence of peers. This was based on this author's belief that the participants would bring to the workshop a wealth of expertise and experiences. Hence, this author used a style of facilitator in the delivery of the workshop. It was also this author's belief, that by using the style of facilitator, it would allow for mutual sharing between this author and the participants. Furthermore, as a facilitator, this author could play the role of resource person, clarifier and guide.

Informal learning was another type of learning used in this practicum. Participants were self-selected based on their willingness to learn and further explore a different working technique. Participants were given the opportunity to determine the goals they had for themselves in regards to the workshop and the ways by which they would execute their new knowledge.

3.3 Description of the Staff Development Activity

It was this author's task to design a staff development program encompassing the techniques and interventions pertaining to adult learning, staff development and solution-focused therapy.

An open system model was used in designing this staff development workshop. Certain steps were eliminated in the design process due to the fact that the appropriateness of the learning program and needs assessment had been accomplished prior to designing the workshop. In conversations with the Mental Health Coordinator, the training specialist from Child and Family Services and a spokesman from Vocational Rehabilitation, a workshop pertaining to solution-focused therapy was viewed as being able to meet the needs of their professional staff and job requirements.

The objectives for this staff development workshop were identified as follows:

1) To develop an understanding of solution-focused therapy.

2) To develop a working knowledge of the techniques and tools used within solution-focused therapy.

3) To learn the techniques used in this therapy model in order to integrate them within professionals' working style.

4) To implement a number of the intervention techniques explored in this workshop when working with clients.

The intent of the workshop was to familiarize professionals with the model and techniques of solution-focused therapy.

The three groups were given a statement describing the intent, objectives, format, and, requirements regarding the two day workshop (See Appendix A).

In creating the learning package to be used in this staff development program, its intent and objectives were constantly referred to. The learning components deemed necessary in order to execute this workshop were identified. The package would include various topics to be covered during the course of the two days: 1) the theories from which solution-focused therapy obtained its grounding; 2) the description of solution-focused therapy; 3) the assumptions of solution-focused therapy; 4) the various techniques of an initial interview when using solution-focused therapy (e.g. joining, matching the clients' language, goal setting, normalizing, exception finding questions, scaling questions, miracle question, the think break, compliments and intervention message, and, tasks); 5) therapist-client relationship patterns; and 6) subsequent interviews. The content to be delivered during the workshop consisted of an educational component that would be transmitted through a lecture format as well as a participatory component which would consist of participants partaking in role plays, discussions, viewing of video tapes and small group exercises.

The content was organized into an instructional sequence covering the two days.

The workshop outline was organized in the following order:

	DAY 1
9:00-10:15	-Introduction of both the facilitator and the participants. A description of each participants' goal is asked for. -The theories from which solution-focused therapy has obtained its grounding. -What is solution-focused therapy?-When to use/ not to use -Assumptions of the model.
	BREAK
10:30-12:00	-Components: Joining Description of complaint Role Play Goal setting Role Play
	LUNCH
1:15-2:30	-Exception Finding Questions -Scaling and coping questions -Miracle question
	BREAK
2:45-4:00	-Role Play -Discussion -Review
	DAY II
9:00-10:00	-Check-in and Review -Intervention Break: Compliments Intervention Message Tasks/Suggestions
	BREAK
10:15-12:00	-Tape; Milwaukee interview -Group exercise pertaining to intervention break -Report on the group discussions
	LUNCH
1:15-2:00	-Finish Milwaukee tape- intervention break -Discussion
2:00-2:30	-Subsequent sessions
	BREAK
2:45-3:00	-Case introduction
3:00-3:15	-Video tape of the case illustration
3:15-3:45	-Role play
3:45	-Testing and Conclusion

A thorough description of the training package can be found in Appendix B.

It was decided that the most effective way to deliver the content was with the aid of audio-visual equipment. Overheads for each topic area covered were produced. A flip chart was also used to help in the delivery of the material. Video tapes were used to demonstrate the how-to-do component of the content information being taught. Handouts pertaining to the techniques discussed were distributed as future resource material. Role plays as well as group discussions and exercises were viewed as an excellent way of implementing experiential learning.

The maximum number of thirty participants were allowed to partake in this workshop.

3.4 Evaluation of the Staff Development Activity

An evaluation component was designed to evaluate the staff development workshop. The participants were given a "Participant Data Form" to complete. The identifying information obtained aided in the completion of a profile of the different participants involved in the staff development workshop. (See Appendix C)

The participants were given a "Participant Feedback Form" to fill out after the workshop (See Appendix D). This form asked the participants to reflect on their knowledge and attitude about solution-focused therapy before and after the staff development workshop. The information obtained would report whether the workshop had changed participants knowledge and attitudes in regards to solution-focused therapy.

The participants were also given a "Participant Satisfaction Questionnaire" which was designed along the lines of the Client Satisfaction Questionnaire developed by

Attkisson (see Appendix E). This questionnaire provided feedback in regards to the quality of the workshop, possible improvements for future workshops and impressions in regards to the facilitator.

The evaluation also comprised of a follow-up interview with 15% of the participants selected randomly. This form of evaluation was viewed as providing more specific information pertaining to the staff development program. This entailed a phone interview with the chosen participants to obtain a qualitative report on the staff development workshop. These phone interviews were conducted six to eight weeks after the workshop. More specifically, the interview consisted of nine questions focusing on three domains: 1) general satisfaction about the workshop, 2) feedback pertaining to the staff development package presented, and 3) how the staff development workshop has impacted upon the participants as professionals.

3.5 The Delivery of the Staff Development Activity

The staff development program was delivered in a workshop format over a two day period. The same content package was used with all three groups. However, the second workshop was co-lead by this author and a colleague. Transparencies were made for most of the topic areas being covered in the workshop. These transparencies were photocopied so that the participants' attention could be on listening rather than on writing. All participants received the same handouts and information. The delivery was in a lecture form and the participatory component consisted of role plays, a group exercise,

and viewing of two taped case scenarios (Milwaukee tape and a taped family interview from this author's caseload).

The first group to receive the staff development workshop was the group from The Pas. There were thirteen participants: four Community Adult Mental Health Workers, one Community Child and Adolescent Mental Health Worker, one Coordinator of Mental Health, three Child and Family Services Worker, one Social worker who did half time Child and Family Services work and half time Community Living work, one full time Community Living Worker, one Family Conciliation Counsellor, and, one Hospital Social Worker. The group was comprised of three men and ten women. Their educational background consisted of B.S.W. (4 participants), R.P.N. (4 participants), B.A. (3 participants), R.N. (1 participant), and Teacher's Certificate (1 participant). Many of the participants had graduated in the 70's and the 80's, 1961 being the earliest year of graduation and 1992 being the latest year of graduation.

Twelve of the participants had more than five years experience in the human services field whereas one participant had between three to five years. Additionally, three participants had one to two years, four participants had three to five years and six participants had more than five years in their present work place.

All thirteen participants reported working with individuals. They also reported working with the following clients: families (10 participants), couples (9 participants), and, groups (1 participant). Seven participants typically had more than ten sessions with their clients, three participants had between five to ten sessions and three participants had less than five sessions.

The group from The Pas had no previous training in solution-focused therapy. However, two of the participants had done some readings in regards to the model.

The delivery of this workshop went relatively well for its first attempt. The group participants asked many clarifying questions which helped this author to be clearer about the material being presented.

The role plays did not unfold as smoothly as they could have due to the fact that the participants were selecting scenarios which were very difficult to play out. They seemed to choose the most challenging case from their caseload and attempted to apply the tools being taught. This resulted in this author telling subsequent groups to use situations that were easy enough to sort out in a short period of time. Furthermore, questions stemming from the role play experiences suggested that there was a need to explore with the groups times when this model does not seem to be as powerful a tool as it could be. This author had incorporated into the workshop time to discuss biases about solution-focused therapy, but this did not seem to be useful given that this group had little knowledge about the model. This discussion was subsequently replaced by situations of when solution-focused therapy does not work as well as it could. In the delivery of the theoretical grounding of solution-focused therapy, this author did not use any visual aids to assist in the delivery of this material. This author sensed that the material could have been presented in a clearer and more interactive manner. The use of a flip chart when presenting this material would be tried for the next group.

Some of the participants from this group had been this author's former co-workers. This author believes that the dynamics remaining from this role should have been

addressed during the workshop. This may have created a more informal atmosphere than the one that seemed to exist during those two days.

The location of the workshop, the board room, was very small and warm. The presentation was often disrupted by participants' need to open a difficult window to provide air into the room. This seemed to effect the participants' level of energy and concentration.

The second group to receive the staff development workshop was Child and Family Services in Winnipeg. Twenty two participants attended the workshop: eight Child and Family Services Workers, six Family Support Workers, three Clinical Case Consultants, two Rehabilitation Workers, one Play Therapy Worker, one Program Consultant, and one Community Mental Health Worker. The group was comprised of seven men and fifteen women. Their educational background consisted of B.S.W (7 participants), M.S.W. (3 participants), B.A. (2 participants), M.Ed. (1 participant) and other programs (9 participants) such as Applied Counselling, Certificate in Chemical Dependency, Social Services Certificate, Advanced Certificate in Child and Adolescent Psychiatry, and, Residential Youth Care Certificate. The majority of the participants graduated in the 80's and 90's with 1979 and 1993 being the earliest and latest years of graduation respectively.

Fourteen participants had more than five years experience in the human services field, five participants had three to five years and one participant had one to two years. Nine participants reported having more than five years experience in their present work, whereas five participants had three to five years, five participants had one to two years

and two had less than one year. Twenty one participants indicated that they work with individuals. They also indicated working with the following clients: families (17 participants), couples (5 participants), groups (15 participants), and, agencies (1 participant). Fifteen of the participants typically had more than ten sessions with their clients, whereas five participants had five to ten sessions and two participants had less than five sessions.

Twelve participants had done some reading about solution-focused therapy in comparison to ten participants who had not done any reading prior to the workshop. Eight participants had previous training in solution-focused therapy in comparison to fourteen participants who had no training in this model.

This workshop was delivered with less apprehensions than the first time. This author had identified during the first workshop a few areas needing improvement and they were incorporated in the content material. Role plays seemed to run more smoothly when participants were encouraged to chose situations which were easier to execute. Having an opportunity to discuss the times when the model is less powerful also seemed to be well received by this group. With this group, a more visual presentation was given than with The Pas group. The presentation on the theoretical grounding of solution-focused therapy was assisted by means of a flip chart. In using the flip chart as a media for delivering the material, the group seemed to be more involved in the presentation, and thus, seemed to interact more with the information given and the facilitator.

This workshop was co-lead by this author's co-worker. The presentation material remained the same as the material delivered to The Pas group, however, the different

topic areas were divided and presented by the two facilitators. The questioned asked were also handled by both co-facilitators. There did not appear to be a difference in the participants' willingness to ask clarifying questions or to participate in the group exercises and role plays. The content delivered by the two facilitators was the same for both groups. Having a co-facilitator for this workshop was very supportive to this author.

The room in which this workshop took place seemed adequate, but, more space would have been needed for the role plays.

This author took the opportunity to examine the learning received from the delivery of the second workshop, and it was decided that the sequence would remain the same and the material presented would be the same. The changes which were incorporated in this workshop, would be kept in delivering the last workshop.

The third group to receive the training was Vocational Rehabilitation. There were thirteen participants: eleven Vocational Rehabilitation Counsellors and two Employment Counsellors. This group was comprised of nine men and four women. Their educational background consisted of B.S.W. (4 participants), M.S.W. (2 participants), B.A. (2 participants), R.P.N. (2 participants), B.Ed. (1 participant), M.Ed. (1 participant) and Counselling Certificate (1 participant). A majority of the participants graduated in the 70's and 80's, with the earliest year of graduation being 1960 and the latest year of graduation being 1987.

Twelve participants had more than five years experience in the human services field, whereas one participant had three to five years. Eight participants had more than

five years experience in their present work, whereas one participant had three to five years, two participants had one to two years and two participants had less than one year.

All thirteen participants reported working with individuals. They also reported working with the following clients: families (5 participants), couples (2 participants), and, groups (1 participant). Seven participants indicated working typically with clients for more than ten sessions, whereas four participants indicated five to ten sessions and two participants indicated less than five sessions.

Eleven participants reported having done reading about solution-focused therapy in comparison to two participants who had not read about the model. Eleven participants had no previous training about solution-focused therapy in comparison to two participants who had obtained prior training about the model.

The different changes incorporated during the second workshop, such as the flip chart and execution of the role plays were again implemented during this workshop. The delivery of this workshop went very well. This author was very familiar with the material being presented and had, through the last two workshops, worked out the snags. The questions that had been asked during the two previous workshops had also helped this author to be clearer and more comfortable with the subject matter. This group seemed to need time to discuss how solution-focused therapy could be used in their workplace. They also needed some time to discuss how the tools being presented could impact on their workplace if they were to use them. This group was interactive and questioned the application of the techniques presented. This author seemed more flexible

in allowing for these discussions to take place. Once the exchange terminated, this author went back to the last point of focus, and continued with the delivery of the package.

CHAPTER FOUR

EVALUATION

4.1 Introduction

This chapter presents a description of the statistical findings pertaining to the staff development. Firstly, a Participant Data Form provided identifying information about the participants (See Appendix C). For a detailed description of the participants in the three locations refer to Chapter three, section 3.5.

Secondly, a ten item Participant Feedback Form provided information regarding the perceived attitudes and knowledge of participant before and after the workshop. Questions 1(a) to 4(b) addressed participants' attitudes about solution-focused therapy. Questions 5(a) to 9(b) addressed their knowledge about this approach. Question 10 dealt with general usage of the approach (See Appendix D). This test shows that the different groups of participants revised their attitudes and were more knowledgeable about solution-focused therapy following the intervention.

Thirdly, a Participant Satisfaction Questionnaire provided information regarding the participants' level of satisfaction with the staff development program. The results show that the three groups were satisfied with the workshop.

Fourthly, data from interviews with 15% (eight) of the participant will be reported. Nine questions were asked and a qualitative reporting of each question will describe the feedback obtained.

This author will also report on a subjective evaluation of her opinions pertaining to the workshops and her abilities as a facilitator.

4.2 The Statistical Findings from the Participant Feedback Form

Four pieces of analysis were conducted on the information obtained through the feedback forms:

(A) Frequencies were run on all cases and a separate analysis was done of the responses from each location (See Table 4-1).

(B) Paired samples t-tests were executed on all participant forms. This involved paired samples t-test on the "before" and "after" points for the combined groups (See Table 4-2).

(C) Paired samples t-tests by group. This involved paired samples t-tests on the "before" and "after" points by group (See Table 4-3).

(D) Independent samples t-test to examine difference between each group at the "before" and "after" points (See Table 4-4).

A total of 47 valid Participant Feedback Forms were examined. Thirteen forms were filled by the group of The Pas, representing 27.7% of the total. Twenty two forms were completed by Child and Family Services, representing 46.8% of the total. Twelve forms were completed by Vocational Rehabilitation, representing 25.5% of the total.

The Participant Feedback Forms asked respondents to comment on their knowledge and attitudes about solution-focused therapy using a 5 point likert type scale. Table 4.1 illustrates the mean score, the standard deviation and the minimum and maximum score for each question.

Table 4-1. Frequencies of all Participant Feedback Forms and Frequencies From Each Group

		All Three Groups		The Pas		Child & Family Services		Vocational Rehabilitation	
		Before (a)	After (b)	Before (a)	After (b)	Before (a)	After (b)	Before (a)	After (b)
Question 1	Mean	4.00	4.45	4.08	4.54	3.91	4.36	4.08	4.50
Importance	S.D.	0.86	0.72	0.64	0.66	1.07	0.73	0.67	0.80
of	Min.	1	3	3	3	1	3	3	3
Solutions	Max.	5	5	5	5	5	5	5	5
	n=	47	47	13	13	22	22	12	12
Question 2	Mean	3.79	4.47	3.77	4.62	3.82	4.36	3.75	4.50
Problem	S.D.	0.88	0.65	1.01	0.65	0.73	0.58	1.06	0.80
vs.	Min.	2	3	2	3	3	3	2	3
Solution	Max.	5	5	5	5	5	5	5	5
	n=	47	47	13	13	22	22	12	12
Question 3	Mean	3.89	3.20	3.85	2.92	3.91	3.43	3.92	3.08
Knowledge	S.D.	0.82	0.81	0.90	0.95	0.77	0.75	0.90	0.67
about	Min.	2	2	2	2	3	2	2	2
Complaint	Max.	5	5	5	5	5	5	5	4
	n=	46	46	13	13	21	21	12	12
Question 4	Mean	3.00	3.76	3.08	3.69	3.14	3.71	2.67	3.92
Rapid	S.D.	0.73	0.64	0.64	0.63	0.85	0.56	0.49	0.79
Change	Min.	2	3	2	3	2	3	2	3
Possible	Max.	5	5	4	5	5	5	3	5
	n=	46	46	13	13	21	21	12	12
Question 5	Mean	2.41	3.89	2.31	3.92	2.52	3.91	2.33	3.83
Knowledge	S.D.	1.02	0.61	0.75	0.28	1.17	0.70	1.07	0.72
about	Min.	1	3	1	3	1	3	1	3
Exceptions	Max.	5	5	3	4	5	5	4	5
	n=	46	46	13	13	21	21	12	12
Question 6	Mean	2.96	4.02	2.85	3.85	3.00	4.00	3.00	4.25
Future	S.D.	0.93	0.65	0.99	0.56	0.97	0.55	0.85	0.87
Oriented	Min.	1	2	1	3	1	3	2	2
Frame	Max.	5	5	4	5	5	5	4	5
	n=	45	46	13	13	20	21	12	12
Question 7	Mean	3.39	4.09	3.39	3.92	3.33	4.05	3.50	4.33
Defining	S.D.	0.65	0.55	0.51	0.28	0.73	0.50	0.67	0.78
Goals	Min.	2	3	3	3	2	3	2	3
	Max.	5	5	4	4	5	5	4	5
	n=	46	46	13	13	21	21	12	12
Question 8	Mean	2.26	3.98	2.08	4.00	2.43	3.91	2.17	4.08
Intervention	S.D.	1.08	0.68	1.04	0.58	1.12	0.70	1.12	0.79
Breaks	Min.	1	3	1	3	1	3	1	3
	Max.	5	5	4	5	5	5	4	5
	n=	46	46	13	13	21	21	12	12
Question 9	Mean	2.33	3.91	2.23	3.85	2.38	3.86	2.33	4.08
Knowledge	S.D.	0.92	0.59	1.01	0.56	0.92	0.48	0.89	0.79
Solution	Min.	1	3	1	3	1	3	1	3
Focused	Max.	4	5	4	5	4	5	4	5
Therapy	n=	46	46	13	13	21	21	12	12
Question 10	Mean	2.39	3.83	2.15	3.69	2.62	3.81	2.25	4.00
Use of	S.D.	0.86	0.64	0.90	0.75	0.87	0.40	0.75	0.85
Solution	Min.	1	3	1	3	1	3	1	3
Focused	Max.	4	5	3	5	4	4	3	5
Therapy	n=	46	46	13	13	21	21	12	12

The three groups combined and the three groups separately are somewhat similar in results. With the exception of question three, which is a reverse scoring, the "after" mean scores are higher than the "before" mean scores (See Table 4.1). A comparison of the average scores "before" and "after" the intervention for the three groups combined, and for each group individually is as follows: all three groups combined had an average "before" score of 3.04 and an average "after" score of 3.96; The Pas group had an average "before" score of 2.98 and an average "after" score of 3.90; the Child and Family Services group has an average "before" score of 3.11 and an average "after" score of 3.94; the Vocational Rehabilitation group had an average "before" score of 3.00 and an average "after" score of 4.06.

When a paired samples t-test comparing the perceived attitudes and knowledge of all participants before and after the workshop was performed (Table 4-2), it showed that in all areas, statistically significant improvement was observed in both attitudes and knowledge ($p < .05$).

A paired samples t-test comparing attitudes and knowledge before and after the workshop by groups (Table 4-3), showed that The Pas had a statistically significant improvement in both attitudes and knowledge (p. < .05). This analysis showed that Child and Family Services had a greater statistically significant improvement in the area of knowledge (p. < .05) than in the area of attitudes. Two of the five attitude questions were not statistically significant. This analysis also showed that Vocational Rehabilitation had a greater statistically significant improvement in the area of knowledge (p. < .05) than in the area of attitudes. One of the five attitude questions was not statistically significant.

Table 4-2. Paired Samples T-Test Comparison of Perceived Knowledge and Attitudes Before and After Workshop for all Three Groups Together.

		Before (a)	After (b)	t-value	df	p
Question 1 Importance of Solutions	Mean	4.00	4.45	-3.58	46	0.001*
	S. D.	0.86	0.72			
	n	47	47			
Question 2 Problem vs. Solution	Mean	3.79	4.47	-5.96	46	0.000*
	S. D.	0.88	0.65			
	n	47	47			
Question 3 Knowledge about Complaint	Mean	3.89	3.20	4.79	45	0.000*
	S. D.	0.82	0.81			
	n	46	46			
Question 4 Rapid Change Possible	Mean	3.00	3.76	-7.32	45	0.000*
	S. D.	0.73	0.64			
	n	46	46			
Question 5 Knowledge about Exceptions	Mean	2.41	3.89	-10.99	45	0.000*
	S. D.	1.02	0.61			
	n	46	46			
Question 6 Future Oriented Frame	Mean	2.96	4.02	-8.55	44	0.000*
	S. D.	0.93	0.66			
	n	45	45			
Question 7 Defining Goals	Mean	3.40	4.09	-6.50	45	0.000*
	S.D.	0.65	0.55			
	n	46	46			
Question 8 Intervention Breaks	Mean	2.26	3.98	-10.70	45	0.000*
	S.D.	1.08	0.68			
	n	46	46			
Question 9 Knowledge about Solution-Focused	Mean	2.33	3.91	-12.18	45	0.000*
	S. D.	0.92	0.59			
	n	46	46			
Question 10 Use of Solution-Focused	Mean	2.39	3.83	-12.98	45	0.000*
	S. D.	0.86	0.64			
	n	46	46			

* significant at $p < 0.05$

Table 4-3. Paired Samples T-Test Comparison of Perceived Knowledge and Attitudes Before and After Workshop By Groups.

		Question 1 Importance of Solutions				Question 2 Problem vs. Solution				Question 3 Knowledge about Complaint				Question 4 Rapid Change Possible				Question 5 Knowledge about Exceptions			
		mean		S.D.	n	mean		S.D.	n	mean		S.D.	n	mean		S.D.	n	mean		S.D.	n
The Pas	Before (a)	4.08		0.64	13	3.77		1.01	13	3.85		0.90	13	3.08		0.64	13	2.31		0.75	13
	After (b)	4.54		0.66	13	4.62		0.65	13	2.92		0.95	13	3.69		0.63	13	3.92		0.28	13
	T-Value		-3.21				-3.39				3.49				-3.41				-7.58		
	df		12				12				12				12				12		
	p		.008*				.005*				.004*				.005*				.000*		
CFS	Before (a)	3.91		1.07	22	3.82		0.73	22	3.91		0.77	21	3.14		0.85	21	2.52		1.17	21
	After (b)	4.36		0.73	22	4.36		0.58	22	3.43		0.75	21	3.71		0.56	21	3.91		0.70	21
	T-Value		-1.94				-4.29				2.02				-4.38				-6.50		
	df		21				21				20				20				20		
	p		.066				.000*				.056				.000*				.000*		
Voc. Rehab.	Before (a)	4.08		0.67	12	3.75		1.06	12	3.92		0.90	12	2.67		0.49	12	2.33		1.07	12
	After (b)	4.50		0.80	12	4.50		0.80	12	3.08		0.67	12	3.92		0.79	12	3.83		0.72	12
	T-Value		-2.16				-2.69				3.46				-5.74				-5.20		
	df		11				11				11				11				11		
	p		.054				.021*				.005*				.000*				.000*		

		Question 6 Future Oriented Frame				Question 7 Defining Goals				Question 8 Intervention Breaks				Question 9 Knowledge of Sol'n Focused				Question 10 Use of Sol'n Focused			
		mean		S.D.	n	mean		S.D.	n	mean		S.D.	n	mean		S.D.	n	mean		S.D.	n
The Pas	Before (a)	2.85		0.99	13	3.39		0.51	13	2.08		1.04	13	2.23		1.01	13	2.15		0.90	13
	After (b)	3.85		0.56	13	3.92		0.28	13	4.00		0.58	13	3.85		0.56	13	3.70		0.75	13
	T-Value		-4.42				-3.74				-9.13				-7.58				-7.15		
	df		12				12				12				12				12		
	p		.001*				.003*				.000*				.000*				.000*		
CFS	Before (a)	3.00		0.97	20	3.33		0.73	21	2.43		1.12	21	2.38		0.92	21	2.62		0.87	21
	After (b)	4.00		0.56	20	4.05		0.50	21	3.91		0.70	21	3.86		0.48	21	3.81		0.40	21
	T-Value		-5.63				-5.09				-6.56				-8.31				-7.28		
	df		19				20				20				20				20		
	p		.000*				.000*				.000*				.000*				.000*		
Voc. Rehab.	Before (a)	3.00		0.85	12	3.50		0.67	12	2.17		1.11	12	2.33		0.89	12	2.25		0.75	12
	After (b)	4.25		0.87	12	4.33		0.78	12	4.08		0.79	12	4.08		0.79	12	4.00		0.85	12
	T-Value		-4.49				-2.80				-4.60				-5.33				-9.75		
	df		11				11				11				11				11		
	p		.001*				.017*				.001*				.000*				.000*		

* Significant at $p < 0.05$

Table 4-4a. Independent Samples T-Test Examining Difference Between Each Location at the "Before" Point.

		Question 1 Importance of Solutions				Question 2 Problem vs. Solution				Question 3 Knowledge about Complaint				Question 4 Rapid Change Possible				Question 5 Knowledge about Exceptions			
		mean		S.D.	n	mean		S.D.	n	mean		S.D.	n	mean		S.D.	n	mean		S.D.	n
The Pas and CFS	The Pas	4.08		0.64	13	3.77		1.01	13	3.85		0.90	13	3.08		0.64	13	2.31		0.75	13
	CFS	3.91		1.07	22	3.82		0.73	22	3.91		0.77	21	3.14		0.85	21	2.52		1.17	21
	T-Value		0.51				-0.17				-0.20				-0.24				-0.59		
	df		33				33				32				32				32		
	p		0.61				0.87				0.84				0.81				0.56		
The Pas and Voc. Rehab	The Pas	4.08		0.64	13	3.77		1.01	13	3.85		0.90	13	3.08		0.64	13	2.31		0.75	13
	Voc. Rehab	4.08		0.67	12	3.75		1.06	12	3.92		0.90	12	2.67		0.49	12	2.33		1.07	12
	T-Value		-0.02				0.05				-0.20				1.78				-0.07		
	df		23				23				23				23				23		
	p		0.98				0.96				0.85				0.09				0.95		
CFS and Voc. Rehab.	CFS	3.91		1.07	22	3.82		0.73	22	3.91		0.77	21	3.14		0.85	21	2.52		1.17	21
	Voc. Rehab	4.08		0.67	12	3.75		1.06	12	3.92		0.90	12	2.67		0.49	12	2.33		1.07	12
	T-Value		-0.51				0.22				-0.04				1.76				0.46		
	df		32				32				31				31				31		
	p		0.61				0.83				0.97				0.09				0.65		

		Question 6 Future oriented Frame				Question 7 Defining Goals				Question 8 Intervention Breaks				Question 9 Knowledge of Sol'n Focused				Question 10 Use of Sol'n Focused			
		mean		S.D.	n	mean		S.D.	n	mean		S.D.	n	mean		S.D.	n	mean		S.D.	n
The Pas and CFS	The Pas	2.85		0.99	13	3.39		0.51	13	2.08		1.04	13	2.23		1.01	13	2.15		0.90	13
	CFS	3.00		0.97	20	3.33		0.73	21	2.43		1.12	21	2.38		0.92	21	2.62		0.87	21
	T-Value		-0.44				0.22				-0.91				-0.45				-1.50		
	df		31				32				32				32				32		
	p		0.66				0.83				0.37				0.66				0.14		
The Pas and Voc. Rehab	The Pas	2.85		0.99	13	3.39		0.51	13	2.08		1.04	13	2.23		1.01	13	2.15		0.90	13
	Voc. Rehab	3.00		0.85	12	3.50		0.67	12	2.17		1.12	12	2.33		0.89	12	2.25		0.75	12
	T-Value		-0.42				-0.49				-0.21				-0.27				-0.29		
	df		23				23				23				23				23		
	p		0.68				0.63				0.84				0.79				0.78		
CFS and Voc. Rehab.	CFS	3.00		0.97	20	3.33		0.73	21	2.43		1.12	21	2.38		0.92	21	2.62		0.87	21
	Voc. Rehab	3.00		0.85	12	3.50		0.67	12	2.17		1.12	12	2.33		0.89	12	2.25		0.75	12
	T-Value		0.00				-0.65				0.65				0.14				1.23		
	df		30				31				31				31				31		
	p		1.00				0.52				0.52				0.89				0.23		

-NOTE- Independent Samples T-Test Based On Pooled Variance Estimate.
-NOTE- Results Significant When $p < 0.05$.

Table 4-4b. Independent Samples T-Test Examining Difference Between Each Location at the "After Point.

		Question 1 Importance of Solutions				Question 2 Problem vs. Solution				Question 3 Knowledge about Complaint				Question 4 Rapid Change Possible				Question 5 Knowledge about Exceptions			
		mean		S.D.	n	mean		S.D.	n	mean		S.D.	n	mean		S.D.	n	mean		S.D.	n
The Pas	The Pas	4.54		0.66	13	4.62		0.65	13	2.92		0.95	13	3.69		0.63	13	3.92		0.28	13
and	CFS	4.36		0.73	22	4.36		0.58	22	3.43		0.75	21	3.71		0.56	21	3.91		0.70	21
CFS	T-Value		0.71				1.19				-1.72				-0.11				0.11~		
	df		33				33				32				32				28~		
	p		0.48				0.24				0.09				0.92				0.92~		
The Pas	The Pas	4.54		0.66	13	4.62		0.65	13	2.92		0.95	13	3.69		0.63	13	3.92		0.28	13
and	Voc. Rehab	4.50		0.80	12	4.50		0.80	12	3.08		0.67	12	3.92		0.79	12	3.83		0.72	12
Voc.	T-Value		0.13				0.40				-0.48				-0.79				0.41~		
Rehab	df		23				23				23				23				14~		
	p		0.90				0.69				0.63				0.44				0.69~		
Cfs	CFS	4.36		0.73	22	4.36		0.58	22	3.43		0.75	21	3.71		0.56	21	3.91		0.70	21
and	Voc. Rehab	4.50		0.80	12	4.50		0.80	12	3.08		0.67	12	3.92		0.79	12	3.83		0.72	12
Voc.	T-Value		-0.51				-0.57				1.33				-0.86				0.28		
Rehab.	df		32				32				31				31				31		
	p		0.62				0.57				0.20				0.40				0.78		

		Question 6 Future oriented Frame				Question 7 Defining Goals				Question 8 Intervention Breaks				Question 9 Knowledge of Sol'n Focused				Question 10 Use of Sol'n Focused			
		mean		S.D.	n	mean		S.D.	n	mean		S.D.	n	mean		S.D.	n	mean		S.D.	n
The Pas	The Pas	3.85		0.56	13	3.92		0.28	13	4.00		0.58	13	3.85		0.56	13	3.69		0.75	13
and	CFS	4.00		0.55	21	4.05		0.50	21	3.91		0.70	21	3.86		0.48	21	3.81		0.40	21
CFS	T-Value		-0.79				-0.94~				0.41				-0.06				-0.52~		
	df		32				32~				32				32				16~		
	p		0.43				0.36~				0.68				0.95				0.61~		
The Pas	The Pas	3.85		0.56	13	3.92		0.28	13	4.00		0.58	13	3.85		0.56	13	3.69		0.75	13
and	Voc. Rehab	4.25		0.87	12	4.33		0.78	12	4.08		0.79	12	4.08		0.79	12	4.00		0.85	12
Voc.	T-Value		-0.14				-1.73~				-0.30				-0.87				-0.96		
Rehab	df		23				14~				23				23				23		
	p		0.18				0.11~				0.77				0.39				0.35		
CFS	CFS	4.00		0.55	21	4.05		0.50	21	3.91		0.70	21	3.86		0.48	21	3.81		0.40	21
and	Voc. Rehab	4.25		0.87	12	4.33		0.78	12	4.08		0.79	12	4.08		0.79	12	4.00		0.85	12
Voc.	T-Value		-0.90~				-0.13				-0.67				-0.90~				-0.73~		
Rehab.	df		16~				31				31				16~				14~		
	p		0.38~				0.21				0.51				0.38~				0.48~		

-NOTE- Independent Samples T-Test Based On Pooled Variance Estimate. ~ Based on Separate Variance Estimate.
-NOTE- Results Significant When $p < 0.05$.

When an independent samples t-test was executed to examine the difference between each group at the before and after point (Table 4-4), it showed that there were no significant differences between the groups before or after the workshop. Each group seemed to be at the same level in all areas prior to and subsequent to the workshop.

4.3 The Statistical Findings of the Participant Satisfaction Questionnaire

Three pieces of analysis were conducted on the information received from the Participant Satisfaction Questionnaire:

(A) Rating of each question for all questionnaires (See Table 4-5).

(B) Rating of each question for questionnaires of each group (See Table 4-5).

(C) Independent samples t-test on question 4 to examine the general satisfaction with the workshop between the three groups (See Table 4-6).

The Participant Satisfaction Questionnaire asked participants to respond to questions pertaining to the material presented during the workshop and the facilitator using a 4 point scale, ranging from a less than favourable response of 1 to a very favourable response of 4.

The rating for each question for all the three groups together, showed that the workshop was well received (Table 4-5). The mean score ranged between 3.26 and 3.87, which corresponded to an above average score on the 4 item scale. This suggest that the staff development program was perceived as being well presented and meeting participant needs. Also the participant satisfaction questionnaire indicated that the participants were generally satisfied with the facilitator's ability to conduct a staff development workshop and presentation of the material covered.

Table 4-5. Comparison of Mean Scores and Frequencies from Questionnaire for each Question for all Three Groups Together and Individually.

		All Three Groups	n	The Pas	n	Child & Family Services	n	Vocational Rehabilitation	n
Question 1	Mean	3.32		2.92		3.36		3.67	
Quality	S.D.	0.59	47	0.49	13	0.58	22	0.49	12
of	Min.	2		2		2		3	
Training	Max.	4		4		4		4	
Question 2	Mean	3.26		3.00		3.14		3.75	
Received	S.D.	0.57	47	0.58	13	0.47	22	0.45	12
What	Min.	2		2		2		3	
Wanted	Max.	4		4		4		4	
Question 3	Mean	3.45		3.23		3.41		3.75	
Recommend	S.D.	0.54	47	0.60	13	0.50	22	0.45	12
to	Min.	2		2		3		3	
Colleagues	Max.	4		4		4		4	
Question 4	Mean	3.36		3.08		3.27		3.83	
General	S.D.	0.64	47	0.76	13	0.55	22	0.39	12
Overall	Min.	2		2		2		3	
Satisfaction	Max.	4		4		4		4	
Question 5	Mean	3.30		3.08		3.37		3.42	
Request	S.D.	0.51	43	0.29	12	0.60	19	0.52	12
Service	Min.	2		3		2		3	
Again	Max.	4		4		4		4	
Question 6	Mean	3.44		3.15		3.43		3.75	
Rate	S.D.	0.62	46	0.69	13	0.60	21	0.45	12
The	Min.	2		2		2		3	
Facilitator	Max.	4		4		4		4	
Question 7	Mean	3.57		3.46		3.52		3.75	
Facilitator's	S.D.	0.50	46	0.52	13	0.51	21	0.45	12
Concern for	Min.	3		3		3		3	
Learning	Max.	4		4		4		4	
Question 8	Mean	3.88		3.77		3.86		4.00	
Was	S.D.	0.34	46	0.44	13	0.36	21	0.00	12
Facilitator	Min.	3		3		3		4	
Prepared	Max.	4		4		4		4	
Question 9	Mean	3.31		3.15		3.20		3.67	
Was	S.D.	0.56	45	0.69	13	0.41	20	0.49	12
Facilitator	Min.	2		2		3		3	
Interesting	Max.	4		4		4		4	
Question 10	Mean	3.38		3.15		3.30		3.75	
Was	S.D.	0.61	45	0.69	13	0.57	20	0.45	12
Facilitator	Min.	2		2		2		3	
Dynamic	Max.	4		4		4		4	
Question 11	Mean	3.52		3.23		3.48		3.92	
Was	S.D.	0.55	46	0.60	13	0.51	21	0.29	12
Material	Min.	2		2		3		3	
Clear	Max.	4		4		4		4	
Question 12	Mean	3.39		3.00		3.38		3.83	
Was	S.D.	0.58	46	0.58	13	0.50	21	0.39	12
Subject	Min.	2		2		3		3	
Covered	Max.	4		4		4		4	

The rating for The Pas group showed that the mean score ranged from 2.92 and 3.77, somewhat lower than the three groups together (Table 4-5). This suggests that the participants were not as satisfied as the three groups together, but nevertheless were generally satisfied.

The rating for Child and Family Services showed that the mean score ranged from 3.14 and 3.86, again lower than the three groups together, but higher than the group from The Pas (Table 4-5). This group was also satisfied with the workshop.

The rating for the Vocational Rehabilitation group showed that the mean score ranged from 3.42 to 4.00, higher than the mean score for the three groups together (Table 4-5). This suggests that this group was very satisfied with the workshop, more so than the three groups together and the other two groups separately.

The differences in the mean score from one group to the next can be explained by the fact that The Pas group was the first group to receive the workshop, whereas the Vocational Rehabilitation group was the last. This author's level of comfort with the material and the role of facilitator seemed to increase after each workshop.

When an independent samples t-test (Table 4-6) was executed on question 4, it was observed that the Vocational Rehabilitation group had a significantly higher overall satisfaction in comparison with The Pas ($p. < 0.05$). This independent samples t-test also demonstrated that the Vocational Rehabilitation group had a significantly higher overall satisfaction in comparison with the Child and Family Services group ($p. < 0.05$). The t-test analysis indicates that there was not a statistically significant difference between the level of satisfaction between Child and Family Services and The Pas. However, the

Vocational Rehabilitation group was more satisfied, overall, with the training than the other two groups.

Table 4-6. Independent Samples T-Test On Question 4 Comparing Overall Satisfaction With The Workshop Between the three groups

Groups	n	Mean	S. D.	t-value	df	p
The Pas Child and Family Services	13 22	3.08 3.27	0.76 0.55	-0.88	33	0.384
The Pas Vocational Rehabilitation	13 12	3.08 3.83	0.76 0.39	-3.09~	23~	0.005*~
Child and Family Services Vocational Rehabilitation	22 12	3.27 3.83	0.55 0.39	-3.12	32	0.004*

* Significant at $p < 0.05$.
-NOTE- Independent Samples T-Test Based on Pooled Variance Estimate.
~ Based on Separate Variance Estimate.

4.4 Qualitative Report of the Follow-up Interviews

Follow-up interviews were conducted with 15% of the participant six to eight weeks after the workshop. The total number of interviewees per group was as follows: two participants from The Pas, four participants from Child and Family Services, and, two participants from Vocational Rehabilitation. The following is a qualitative report of the participants' responses by question.

Question 1 Since the staff development workshop, how have you become more interested in solution-focused therapy?

Since the workshop, four of the participants said they were reviewing the handouts and the notes taken during the workshop. In fact, one was reviewing the handouts as a way of preparing for interviews with clients. One participant had attended another workshop in solution-focused therapy since this workshop. Two participants indicated that they were very excited about the concepts from the model and that they have been reading books and articles to obtain more in depth information. Two of the participants were questioning how they could integrate this model in their present working style. One participant was going to attempt to use this model in a group with survivors of sexual abuse. Another participant had been attempting to phrase questions by using more solution-focused language.

Question 2 What benefits do you think you gained from the staff development workshop?

The majority of the participants (six out of the eight) indicated that the workshop gave them more clinical tools to work with. Here is a list of the benefits reported:

-help clients find the resources which will aid in their change process, by using tools such as the miracle question, exception finding questions, scaling questions and pointing out differences;

-tools to help clients take more responsibility in identifying short term goals. At one time this professional would tell the clients about his/her options but now gives the client the opportunity to explore what would work for them;

-the resources and techniques received from this model can aid in overcoming or breaking down road blocks that the client has put in front of them, such as negative thinking;

-the workshop was a reminder to look for positive and to be more positive with clients. The assumption of "if it's not working, stop", and "if it's working, do more of it" is useful in helping families with their struggles;

-has provided ideas in regards to more open-ended questions;

-usage of a more solution-focused language, relationship and circular questioning to help identify problems and solutions;

-being more aware of where the client is and what their wants and needs are.

Question 3 Are you doing anything different in your work with your clients as a result of the staff development workshop? If not, why not?

All of the eight participants indicated that they are much more aware of the way they ask questions when interviewing clients. Two participants said they ask questions in a more positive manner with the intent of exploring positive and exceptions. As a result, they felt they get less caught up with the problem. One participant shared that when one points out positive and strengths, this can prevent worker burnout and can also

empower the clients. One participant had been using cheerleading techniques, for, this person felt this was an excellent emotional motivation for clients and also helped in pointing out positive. One of the participant said that the technique of reframing was being used more frequently in this person's working style.

Four participants said they are using the tools of the model in a more defined process and context. The miracle question, scaling questions, exception finding questions and relationship questions were being incorporated in the participants' style of working. In fact, one participant indicated that her work place has been very excited about the solution-focused approach and is intending to incorporate it into their admitting, treatment and case planning.

For three of the participant, knowing that the clients' history is not always helpful at identifying changes sought by clients, had helped them to focus on the here and now and zero in on the goals much quicker.

Question 4 Have you had the opportunity to talk this out and its application with other colleagues? What was the outcome?

Four participants did not discuss with colleagues the workshop or the skills learned during the workshop. They mentioned that time and heavy caseloads did not allot them the opportunity to share ideas and information. Two participants did indicate that on the day of the workshop, they talked with other participants about how they would apply the model and how it could be useful with their clinical work with clients. One participant shared that in supervision, a solution-focused approach was used to discuss and plan for

the case in question. One participant had been sharing the theoretical background of the model with colleagues in order to help them be more understanding of the approach.

Two participants had been discussing with colleagues how they could integrate the solution-focused approach in their agency as well as in their work with clients. One participant and this person's team had talked about selecting a few cases and working with them by using the solution-focused approach as their form of intervention. However, lack of time and motivation have prevented this from happening.

One participant prepared a short presentation about the workshop to colleagues. This person mentioned that these colleagues reported having used the material presented and found it helpful in their work.

Question 5 In your work with clients, in what ways have you been finding successes and struggles with the techniques?

Seven participants reported successes with the techniques discussed during the workshop. One participant had not had the time to use the model, although this person would like to do so. The participants were experiencing successes with the miracle question, exception-finding questions, and, looking for differences when the problem does not exist. They were finding that clients tend to give much more information when their line of questioning is more positively framed. One participant shared that this approach streamlines the interview process. It reduces interview time and yet can arrive at the point of decision-making more quickly.

Different examples were given by the participants of their successes. One participant said this approach was used with a boy from a dysfunctional home. This boy began to explore how he can make things better for himself. He could think for himself and begin to feel like he had some control in some aspects of his life.

One participant shared that this technique worked very well with teenagers: "kids eat it up." The approach turned them around to view issues in a more positive frame. Another participant mentioned that scaling questions were used within a group setting and the dynamics of this group improved.

One participant shared that the miracle question worked very well in gathering information from a child who had said very little during the interview. Another participant shared that the miracle question was helpful in sorting out a conflict between foster parents and a child.

The struggles were identified as follows:

-framing questions so that they are asked in a positive way

-integrating the tools learned by reflecting upon and changing old techniques which are not as useful and helpful to clients

-some clients are very receptive but others have a difficult time with the techniques used by the professional. How does one work with these clients?

-incorporation of this model in supervision

-using the model in an effective way when working with issues of sexual abuse

-posing questions to young children without giving them false hopes.

Question 6 What part of the staff development workshop was the most helpful to you? Explain.

All of the eight participants had found different aspects of the workshop helpful in their present work with clients. The workshop was viewed as being concrete and understandable. One participant was pleasantly surprised by the information received during the two days. One participant felt that the future-oriented questions helped him to be less tempted in answering questions for clients by allowing them to struggle with their answers. Three participants shared that the role plays were useful in bringing to life the tools being discussed in the workshop. One participant said that the case illustration video was very helpful in illustrating the model in a concrete and tangible manner. The grounding of solution-focused therapy was viewed as being very helpful for two of the participants. This made the model more understandable. Three participants felt it was helpful to be away from the office to network with other professionals and to discuss how they are working with clients.

Question 7 What part of the staff development workshop was the least helpful? Explain.

Five participants could not think of anything that was least helpful about the workshop. Nothing stood out as needing improvements. One participant shared that the role plays could have been more structured so that less time was wasted by the groups in designing their own case scenario. One participant felt that there was too little time for experiential exercises to practise the techniques being presented. One participant

shared that listening to other workers share case examples was confusing and disruptive to this person's own learning of the model.

Question 8 What would you change to improve this staff development workshop?

Six participants felt that the role plays could have been conducted in a different manner. The feedback received indicated that the role plays could have been more organized and structured by the facilitator. Also, a group role play could have been executed along with the small group role plays. Watching the facilitator role play could have demonstrated how the techniques can be used in counselling.

Two participants felt that the location of the workshop was an issue. They would have preferred a different location with less disruptions.

Question 9 What kind of follow-up program, if any, would be the most helpful to you and your group?

The eight participants felt that a gathering of people involved in the workshop with the purpose of discussing how they are using the model, how they have integrated the techniques, their struggles and successes with the model and ideas about incorporating the model within their work was viewed as a useful follow-up. This would fulfil three goals: Provide a refresher about the model, reassure that the techniques are being used properly and networking with other professionals.

4.5 Evaluation of Self

This author believes that the staff development workshop was well designed. It was concrete and very experiential in nature. The content presented was meant to be work oriented so that when the participants left the workshop they could begin to incorporate the techniques in their own practise. Its content was geared for professionals either unfamiliar with solution-focused therapy or minimally familiar with it. For those professionals very knowledgeable with its approach, the material presented could serve as a review.

As a facilitator, this author was very nervous presenting to her first group. This was this author's first experience at delivering a two-day workshop. The added pressure for this author was the fact that some of the members in this group were former colleagues. It seemed that this author was very attached to her material and did not sway much from the agenda. In delivering the second workshop, it appeared that this author was much more relaxed and less married to the package. This author was more comfortable in answering questions and being lead by the participants' agenda. By the third workshop, this author was very relaxed with the material being presented. The participants were given ample room to discuss their issues being raised by the workshop content without being rigidly directed back to the task at hand. I also seemed to invite the participants to discuss among themselves their apprehensions concerning the approach and their workplace. I facilitated these discussions by introducing concepts stemming from solution-focused therapy.

It seemed very important that this facilitator presented herself as a resource person rather than an expert. Encouraging the participants to recognize their prior skills aided in keeping their interest in the material being presented. At times, some of the participants appeared to argue against different points. This may have been a sign that the participants' expertise and skills were being challenged. This could have also been a sign that the participants were feeling overwhelmed with all the new information. Also, this could have been a sign that the participants were feeling the desire to incorporate the new skills discovered during the workshop but were feeling the need to postpone this due to time restraints and high caseload demands.

This author agrees with the participants interviewed in the follow-up. The role plays could have been more structured. During the workshop role plays, this author noticed that the participant would select case scenarios which were so difficult in nature, that the purpose of practising the techniques was lost. With more organization, the role plays could have been a more powerful tool.

The facilitator who co-lead the second workshop with Child and Family Services, reported that the workshop was well organized and all of its pieces fit well together. The content material was clear and not too overwhelming; the amount of information given was sufficient. There was also an adequate amount of role plays. However, the role plays could have been designed by using a fictitious situation to demonstrate the techniques being presented. Also, the pacing could have been changed at times. More specifically, more group and individual exercises could have been conducted to break the lectures and the role plays.

As a facilitator, the co-facilitator described this author as being informal. This author did not present herself as being an expert but rather as a resource person. The atmosphere created by this author was comfortable, therefore, participants felt at ease in participating and questioning.

CHAPTER FIVE

CONCLUSIONS AND RECOMMENDATIONS

5.1 Conclusion

The intent of the staff development program was to present a workshop that would enhance participants' learning in solution-focused therapy without necessarily having as an outcome the incorporation of the learning in their present workplace. The staff development program focusing on a two-day workshop about solution-focused therapy seemed to enhance participants' knowledge and attitudes concerning the material presented. Assuming that the follow-up interviews are representative of all the participants, they suggest that the participants interviewed are attempting to integrate the tools and the skills presented during this workshop into their working styles. It would appear that time and motivation seems to interfere with the application and continued interest in the material presented during the workshop. When a participant has made the commitment to do something different in their work style following a staff development program, they seem more likely to follow through with this commitment than a participant only wanting a break from the work site or involved due to an interest in the subject matter. The results of the evaluation may have been affected by the fact that the facilitator admininstered the questionnaires and also conducted the follow -up interviews.

This author's personal reaction to the three workshops was that the delivery went well. It was this author's belief that The Pas enjoyed the workshop the least, whereas, Child and Family Services had enjoyed the workshop, but, not as much as Vocational Rehabilitation. The evaluation supported this reaction in a statistically significant manner. This suggests that the evaluative component of a staff development program is very important. Discussing outcome and enhancement is more objective and can be supported by quantitative reporting.

Having a well designed program was helpful. Knowing that a core presentation of skills and material was designed, made it possible to be more flexible with the groups. Experience in delivering this workshop enhanced this author's comfort with the material presented, the questions asked and the participants' individual agendas. More sharing by the participants was noticed and this facilitator felt less like an expert and more like a resource person struggling with some of the same issues they were addressing.

5.2 Recommendations

External variables, such as work load, dynamics between workers, unresolved conflicts, travelling and reasons for attending a staff development program needs to be considered by the facilitator. The delivery and the outcome can be influenced by these variables and if they are not taken into consideration, a facilitator may look in all the wrong places for the causes of a poor outcome. In particular, facilitators delivering a staff development program to former co-workers should address the ghosts of this prior

role before pursuing with the task at hand. This can reduce the tension and the resistance created by unresolved issues.

In creating the staff development program, a needs assessment was not deemed necessary given that representatives expressed and discussed with this author the needs and wants of their respective groups. However, if the needs remain unclear or if the facilitator is interested in the needs of each individual of a group, a closed systems design model may be exercised. A thorough needs assessment will need to be conducted prior to designing and implementing the learning activity.

Being aware of participants' goals and agendas regarding their involvement in a staff development program is important. Without this input, participants may not partake as much in the program, thus, resulting in less growth and learning. It is recommended that professionals be viewed as having competencies and skills which can be enhanced upon during a staff development program. If participants are feeling dismissed or belittled, they may react in a resistant and defensive manner.

Being a facilitator and resource person rather than an expert when presenting to adult participants is useful and important to the learning and growth of all involved. This role allows for exchanges to take place and for the facilitator to learn as much from the participants as they will learn from the facilitator.

When presenting a workshop as a staff development program, more than one presentation should be planned. Experience and feedback allows for changes to take place, resulting in a better quality workshop.

Participant Satisfaction Questionnaires should include closed-ended and open-ended questions. Asking participants to explain questions such as what was the most/least useful component about the workshop, what would you have liked included in the workshop etc., will give more information to create future changes in order to improve the quality of the activity.

When possible, the person to person follow-up evaluation of a staff development program should be conducted by an individual other than the facilitator. This can decrease biases and skewed answers.

REFERENCES

Austin , M., J., Brannon, D., and Pecora, P., J., (1984). Managing Staff Development Programs in Human Service Agencies. Chicago: Nelson-Hall Publishers.

Berg, I. K., (1991). Family Preservation: A Brief Therapy Workbook. London: Bt Press.

Berg, I. K., (1990). A Guide to Practice: Constructing Solutions in In-Home Treatment. Milwaukee: Brief Family Therapy Center.

Dastoor, B., (1993). The Psychology of Learning, Training and Development, June, 17-22.

de Shazer, S. (1985). Keys To Solution in Brief Therapy. New York: W. W. Norton and Company.

de Shazer, S. (1988). Clues: Investigating Solutions in Brief Therapy New York: W. W. Norton and Company.

de Shazer, S. (1991). Putting Difference to Work. New York: W. W. Norton and Company.

Doelker, Jr., R., E., (1977). Lifelong Learning: An Approach to Continuing Education for Social Work. In Taylor, L., and Hutton, M., Editor (1987). Continuing Education In Social Work: Literature Review for The Continuing Education In Canadian Social Work Project. Sponsored by NHW Canada.

Doherty, W. J., and Baptiste, D., A. Jr., (1993). Theories Emerging from Family Therapy. In Boss, P. G., Doherty,W. J., LaRossa, R.,Schumm, W. R., and Steinmetz, S. K., Eds. (1993). Sourcebook of Family Theories and Methods (pp. 505-524). New York: Plenum Press.

Doueck, H., J., and Bondanza, A., (1990). Training Social Work Staff to Evaluate Practice: A Pre/Post/Then Comparison Administration in Social Work, Vol. 14, No. 1, 119-133.

Efran, J. S., Lukens, J., Lukens, M. D., (1988). Constructivism: What's in it for you? The Family Therapy Networker, September/ October, 27-35.

Furman, B., and Ahola, T., (1992). Solution Talk: Hosting Therapeutic Conversations. New York: W.W. Norton & Company Inc.

Gibelman, M., and Humphreys, N., A., (1979). In Taylor, L., and Hutton, M., Editor (1987). Continuing Education In Social Work: Literature Review for The Continuing Education in Canadian Social Work Project. Sponsored by NHW Canada.

Huber, C., H., and Backlund, B., A., (1991). The Twenty Minute Counselor: Transforming Brief Conversations into Effective Helping Experiences. New York: The Continuum Publishing Company.

Jarvis, P., (1983). Adult and Continuing Education: Theory and Practice. London: Croom Helm, New York: Nichols.

Jorgensen, J., and Klepinger, B., W., (1979). The Social Worker as Staff Trainer, Public Welfare, Winter, 41-49.

Knowles, M., (1984). Adult Learning: Theory and Practice. In Nadler, L., Editor (1984). The Handbook of Human Resource Development (pp. 6.1-6.22). New York: John Wiley and Sons Inc.

Knowles, M., (1978). The Adult Learner: A Neglected Species (2nd Edition). Houston, Texas: Gulf Publishing Company.

Knowles, M., (1977). Adult Education, Encyclopedia of Social Work, Vol. 1, No. 17, 52-55.

Knowles, M., (1972). Innovations in Teaching Styles and Approaches Based Upon Adult Learning, Education For Social Work, Spring, 32 -39.

Koch, W., H., and Brenner, M., N., (1976). Continuing Education for Social Service: Implications from a Study of Learners. Journal of Education for Social Work, Winter, Vol. 12, No. 1, 71-77.

LaRossa, R., Reitzes, D. C., (1993). Symbolic Interactionism And Family Studies. In Boss, P. G., Doherty,W. J., LaRossa, R.,Schumm, W. R., and Steinmetz, S. K., Eds. (1993). Sourcebook of Family Theories and Methods (PP. 135-163). New York: Plenum Press.

Miller, H., G., Verduin, John, R., Jr., (1979). The Adult Education; A Handbook For Staff Development. Houston, Texas: Gulf Publishing Co.

Nadler, L., (1984). Human Resource Development. In Nadler, L., Editor (1984). The Handbook of Human Development (pp. 1.1-1.47). New York: John Wiley and Sons Inc.

Nadler, L., and Nadler, Z., (1989). Developing Human Resources (3rd Edition). San Francisco, California: Jossey Bass Inc.

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

Osmond, M. W., Thorne, B., (1993). Feminist Theories: The social construction of gender in families and society. In Boss, P. G., Doherty, W. J., LaRossa, R.,Schumm, W. R., and Steinmetz, S. K., Eds. (1993). Sourcebook of Family Theories and Methods (pp. 591 -623). New York: Plenum Press.

Philips, J., (1984). Evaluation of Human Resource Development Programs: Quantitative. In Nadler, L., Editor, (1984). The Handbook of Human Resource Development (pp 12.1-12.30). New York: John Wiley and Sons Inc.

Reed, J., (1993). Learner-Centered Learning, Training and Development, 20-22.

Rothman, B., (1973). Perspectives on Learning and Teaching in Continuing Education, Education for Social Work, Spring, 39-52.

Tough, A., (1981). Interests of Adult Learners. In Chickering, A., W., and Associates, (1981). The Modern American College: Responding to the Realities of Diverse Students and a Changing Society (pp. 296-305). San Francisco, California: Jossey-Bass Inc.

Walter, J. L., Peller, J. E., (1992). Becoming Solution Focused in Brief Therapy. New York: Brunner/Mazel Publishers.

Whitchurch, G. G., Constantine, L. L., (1993). Systems Theory. In Boss, P. G., Doherty,W. J., LaRossa, R.,Schumm, W. R., and Steinmetz, S. K., Eds. (1993). Sourcebook of Family Theories and Methods (pp. 325-352). New York: Plenum Press.

Wiggs, G., D., (1984). Designing Learning Programs. In Nadler, L., Editor (1984). The Handbook of Human Resource Development (pp. 7.1 -7.35). New York: John Wiley and Sons Inc.

Zimmerman, S., L., (1978). Continuing Social Work Education: Why do Social Workers Participate in Continuing Education Programs? Journal of Education for Social Work, Spring, Vol. 14., No. 2, 111-116.

APPENDICES

APPENDIX A

WORKSHOP OUTLINE GIVEN TO PARTICIPANTS

PRIOR TO THE WORKSHOP

STAFF DEVELOPMENT: WORKSHOP IN SOLUTION-FOCUSED THERAPY

This workshop is open to professionals within the Agency who are currently carrying a caseload. Previous knowledge of Solution-focused approach is not necessary.

OVERVIEW:

The workshop is designed to give professionals working within the human services field an overview of Solution-Focused Approach. Assumptions, techniques, and, tools used within this approach will be presented.

LEARNING OBJECTIVES:

1) To develop an understanding of Solution-Focused Approach.
2) To develop a working knowledge of the techniques and tools used within a Solution-Focused Approach.
3) To learn the techniques used in this approach in order to integrate them within professionals' working style.
4) To implement a number of the intervention techniques explored in this workshop when working with clients.

FORMAT:

The entire two days of the workshop will revolve around an exploration of Solution-Focused Approach. The workshop will be presented in lecture form and may

include role plays and case examples, all having the goal of examining the techniques used by this Approach.

The workshop content will consist of the following: 1) from which theoretical base does Solution-Focused Approach stem from, 2) the assumptions of the approach, 3) description of the tasks and techniques used within an interview, and, 4) exploration of goal setting, scaling questions and miracle question or future oriented questions.

Given that the staff development workshop is a requirement for the completion of a M.S.W. degree, the participants will be asked to complete the following questionnaires: a participant data form, a pretest, posttest and then test to be completed prior to and following the workshop, a participant satisfaction questionnaire to be completed following the workshop and 15% of the participant selected randomly will be asked more in depth questions regarding the workshop.

READINGS:

A copy of a number of readings will be given to participants prior to the workshop. The readings will supplement the workshop and can be used as reference material following the workshop.

APPENDIX B

THE TRAINING PACKAGE

The Training Package

The theories from which solution-focused therapy obtained its grounding:

Solution-focused therapy is a model of intervention which has been strongly influenced by family therapy theories (Berg, 1991). In particular it has borrowed from the works of Bateson, Milton Erickson and the Mental Health Institute (de Shazer, 1985).

Bateson was very interested in "the difference which makes the difference or an idea that is the news of difference" (de Shazer, 1982, p. 73). Solution-focused therapy pays close attention to exceptions to the problem when a difference can make a difference. Bateson's notion that ideas develop from having two or more descriptions of the same process, pattern or sequence that are coded or collected differently helped to create the assumption that there are no right or wrongs in solution-focused therapy but only differences which are useful and creative (de Shazer, 1985). According to de Shazer (1985) the concept of differences was the beginning of a poly-ocular view to situations.

Solution-focused therapy is an interactive process which involves the clients, therapist(s), and the context in which they work together. According to Walter and Peller (1992) "therapy becomes an interactional or joint experience, with problems and goals constructed or negotiated between client and therapist" (p. 6). Clients will often come into therapy presenting their problems in such a way that the difficulties are viewed as a fact of life or an unchangeable steady state. However, when asked, clients can describe when the problem does not exist. For the client this is not a difference that can make a difference. It becomes the role of the therapist to deconstruct these misperceptions and

co-create a new meaning in order to build solutions. de Shazer (1988) explains that when a therapist deconstructs misperceptions, the therapist is accepting the client's frame as logical up to the point where it produces troublesome behaviour, thoughts, feelings and perceptions as well as exploring the client's situation, sometimes in great detail and at great length looking for exceptions and promoting whatever is useful and helpful to the client.

de Shazer (1991) states that solution-focused therapy was greatly influenced by the works of Watzlawick on reframing, a constructivist concept, and the Brief Therapy Centre at the Mental Health Research Institute (MRI). Reframing changes the client's viewpoint by placing it in another frame which fits the same situation equally well or even better, thus changing the entire meaning. The effect of this repositioning causes changes in behaviours, perceptions, emotional states and beliefs. Once the client can see things differently, they can begin to behave differently.

The MRI view on brief family therapy caused this group to begin to sway away from the family therapy theory's belief that clients' problems as being a reflection of a dysfunctional social organization within the family (de Shazer, 1991). They began to look at the interactional patterns and the here-and-now of the therapeutic process as important rather than looking at causal explanations for complaints. The intervention was geared around behavioral changes described by the client as being problematic. They began the brief therapy notion that no matter how complex the situation, a small change in one person's behaviour can make a profound difference in the behaviour of all the people involved (de Shazer, 1985). In the MRI brief therapy model, the therapist along

with the client works out the definition of the therapeutic goals. MRI began to shift the boundaries from around the client-plus-problem to the client-plus-problem-plus-therapist (de Shazer, 1991). Solution-focused therapist went one step further and redefined the unit of analysis as involving client-plus-therapist-plus-goal or solution. de Shazer (1991) explains that "solution-focused therapy is seen as a mutual endeavour involving therapists and clients together constructing a mutually agreed upon goal" (p. 57).

Milton Erickson also had an impact upon brief family therapists. Erickson's notion of balance-theoretical maps helped solution-focused therapy to begin mapping solutions on the same map as that used to mapped complaints (de Shazer, 1985). This means that symptoms or complaints are accepted and rather than trying to eliminate them, they are transformed into parts of the solution. Furthermore, Erickson's confusion technique (de Shazer, 1985) was also adjusted to solution-focused therapy. It involves exploring in detail each point of difference between two or more people without any attempts at closure or resolution and then openly admitting one's confusion in regards to their confusion (de Shazer, 1985). This technique allowed for a new construction of meaning and goal setting between the therapist and the client(s). Erickson's contribution to hypnosis is also used in solution-focused therapy. Although clients are not put into a trance, different techniques are exercised which creates and invites a "yes set" for the client: They are asked future oriented questions which presupposes change, the therapist's use of language also presupposes change, the miracle question takes the client into the future, compliments and breaks and intervention messages are all hypnotic techniques.

Solution-focused therapy has taken its roots from systems theory. It assumes that all parts are interconnected and interrelated. Solution-focused therapy also assumes that minimal change is needed to begin solving complaints and that once the change is initiated, further changes will be generated by the client.

Solution-focused therapy also shares the systems theory concept of equifinality. Solution-focused therapists believe that there are more than one way of viewing a situation, none more correct than others.

Solution-focused therapy tends to give importance to the systemic concept of wholism (de Shazer, 1985). In solution-focused therapy, since interactive patterns can be seen as both individual and systemic habits, all it would take is for one person to behave differently to break the habit (de Shazer, 1985).

Unlike systems theory, solution-focused therapists do not believe that the family unit will respond to change in a way to maintain a homeostatic balance and maintain its boundary. Berg (1991) states that solution-focused therapy views change as inevitable and constantly occurring. Solution-focused therapy sees stuckness. People would like things to be better, but are constantly repeating the same patterns of behaviour with the hope that things will eventually change.

This author believes that feminist theory has to some extent influenced solution-focused therapy. Solution-focused therapy finds it important to view the client as an expert in regards to their situation. The notion of empowerment of clients is central to solution focused therapy. Berg (1991) describes the following features used in empowering: 1) the client-worker relationship is a collaborative venture, 2) it is

assumed that the client is competent to know what is good for them and their family, 3) it assumes that the client has the ability to solve problems and has done so in the past, 4) the clients negotiates the goals for therapy, and, 5) it is an approach that respects client autonomy and personal, familial and cultural boundaries, and is less intrusive.

What is Solution-focused therapy?

For a number of years, helpers using a brief model of intervention in therapy have been exploring new and innovative ways of dealing with consumers' complaints. Both the Mental Health Institute in Palo Alto and The Brief Family Therapy Institute in Milwaukee have shown that 72% of their cases have either met their goal for treatment or have made significant improvement within an average of seven sessions (de Shazer, 1985). Notably, Steve de Shazer and his colleagues from the Milwaukee team developed an approach which is less problem focused and more solution oriented (de Shazer, 1985). Therefore, many professionals are focusing on solutions rather than problems as the focus for treatment (Miller, 1992). Solutions tend to exist in the present and future whereas, problems are rooted in the past. Solutions are a reflection of what people can already do, while problems come about as a result of what people cannot do. Miller (1992) states that if solutions are ignored they tend to disappear. Solution-focused treatment gives particular attention to exceptions or when the complaint does not seem to occur. By paying close attention to exceptions or as to when the problem does not exist, exceptions become a key to finding solutions. Berg (1991) states that "it is easier to enlarge on the existing change, however small, than to create something that does not exist" (p. 11).

Therefore it can be said that it would be easier and more profitable to develop solutions rather than to dissolve problems.

Solution-focused therapists ask questions in therapy which are meant to elicit information about strengths, abilities, and resources. Clients' problems and how they are viewed change significantly through this kind of questioning. Solution-focused therapists see themselves as participants in the co-creation of clients' reality. Lipchik and de Shazer (1986) state that the interview is more than a tool for gathering a description of the complaint within the client's frame and information about the interactional patterns of the system. The therapist's responses during the session is seen as a significant part of the change process. Therefore, generally speaking, the therapist's focus when using a solution-focused treatment modality is on talking about change, searching for differences that make a difference, and solutions rather than talking about difficulties, complaints and problems. Linear and circular questioning are used to further understand the complaint. However, they are mainly used to find out what is different when the client does not experience the complaint, and to build on these exceptions, and/or to question the client about their ideas in regards to solutions and how they will be accomplished.

O'Hanlon and Weiner-Davis (1989) state that in solution-focused therapy, therapists are trying to do three things: 1) change the pattern of a situation that is perceived problematic; the goal is to change actions and interactions so that the client can resolve their situation rather than repeat unsuccessful patterns: 2) change the viewing of the situation that is perceived as problematic; changing clients' frame of reference can lead to changes in behaviour: 3) evoke resources, solutions and strengths

to bring to the situation that is perceived as problematic; reminding and exposing people's resources, strengths and abilities can lead to changes in behaviour and view point.

At this point in the workshop, a discussion about when solution-focused therapy works well as an intervention technique will take place.

Assumptions About Solution-Focused Therapy:

1) It is important to utilize what the consumer brings to therapy. Consumers know what is best. They are expert about their problem; experts about their own lives and have the resources to solve their problems.

2) It is not necessary to have detailed knowledge about the complaint in order to resolve it.

3) It is not necessary to know the cause or function of a complaint in order to resolve it.

4) Cooperation is necessary and mandatory. The notion of resistance does not exist. Resistance is created when the therapist has not heard the client and is imposing her/his own views.

5) All parts of the system are interconnected and interrelated. This is a concept deriving from systems theory which says that each part of the system affects and is affected by the other parts of the system. Therefore, when one part of the system changes , the other parts will also change in order to accommodate to the original change thus creating a fall out known as the ripple effect.

6) A small change in a system may lead to bigger changes. Therefore, a big problem does not necessitate a big solution. Small changes are needed and will ripple to create other changes. Use small and simple solutions first. At times one can overlook a very simple solution while looking for a big solution.

7) There are many ways of looking at a situation, none more correct than others.

8) Consumers define the goal, which are also co-defined with the therapist.

9) Change is constant and inevitable. Given that we are in constant state of change, it is important to capitalize on the changes and influence the necessary changes in a positive way.

10) Focus on areas which are changeable and within the client's control.

11) It is easier to build on success than it is to stop an undesirable behaviour. It is much easier to continue doing what works and to enlarge on this behaviour which will create change.

    i) Pay attention to when the problem is not a problem.

    ii) If it works, don't fix it. In fact, do more of it.

    iii) When it does not work, do something different.

12) Rapid change is possible.

Components of Solution-Focused Interviewing:

The proceeding presentation is this author's interpretation of the model based on readings concerning Solution-Focused Therapy and workshop attended on the subject matter as well as years of experimentation and experience with the model.

During the initial interview, different techniques will be used to conduct the therapeutic process.

JOINING:

During the first part of the interview, **joining** is very important. This is the time to set a social stage and connect with clients on a more neutral ground. The therapist needs to pay particular attention to the clients' language and use of words as well as her/his own. Language is used to solidify certain views of reality and to also question unhelpful certainties. O'Hanlon and Weiner-Davis (1989) state that creative and mindful use of language may be the single most influential indirect method for creating contexts in which change is perceived to be inevitable. The therapist can use language which presupposes change without stating it directly. For example the therapist can ask the following question which presupposes that the counselling will be successful:

"What will be different in your life when therapy is successful?"

MATCHING THE CLIENT'S LANGUAGE:

Matching the clients' language is another useful technique used in building rapport and cooperation. One aspect of matching the clients' language is to mirror the clients' exact words (O'Hanlon and Weiner-Davis, 1989). At times key phrases can be used in the intervention message given at the end of the interview. Other aspect of matching clients' language involves using clients' metaphors and/or matching sensory modalities (O'Hanlon and Weiner-Davis, 1989).

Initially the clients' language will be used, but as the session progresses, the meanings for words will begin to take a direction which can be more helpful to the

change process. Language having fixed, negative meanings are channelled into action descriptions. O'Hanlon and Weiner-Davis (1989) state that it is much easier to deal with actions than with fixed characteristics for they are visible and measurable. It can also have the effect of depathologizing or normalizing clients' situations.

O'Hanlon and Weiner-Davis (1989) suggest that careful use of **verb tenses** can also be important by creating a reality that the problem is in the past and change is for the present and future. The use of the word "yet" is used a great deal for it implies that eventually a change will occur. Furthermore, questions are asked using definitive terms rather than possibility terms. For example, **"What will be different in your life when the two of you are getting along better"** or **"Who will be the first to notice when the problem is gone"**. Definitive terms are used to challenge unhelpful beliefs held by clients. This is a way to keep possibilities open for the present or future, especially when you are dealing with a client who has closed down possibilities of any changes taking place.

DESCRIPTION OF THE COMPLAINT:

The second component of a solution-focused interview is the **description of the complaint.** The therapist's goal is to redirect clients from the frame of complaining towards a solution frame. The balance between giving clients ample opportunity to discuss and share complaints is needed without getting too caught up in problem focused counselling. When the client has sufficiently shared their complaints, and this is often recognized by a pause in their story telling, the therapist can now move the session in the direction of solutions. Questions such as **"what brings you in today?"** or **"What is**

your goal in coming here?" begins the description of the complaint. When clients are stuck in the complaint or wish level, Walter and Peller (1992) suggest the following questions to move from wishes or complaints towards a statement of a goal or problem:

"I am very sorry to hear how things are going. Can you tell me what about this you would like to change or in what ways you would like to be handling things differently?" This questions supports the clients' feelings and asks a goal-oriented questions requiring a change in thinking.

"I am sorry to hear how badly things have been. Can you tell me what about this I can help you with?" This question asks how you can be helpful as a therapist.

"I am very sorry to hear how badly things are going. Can you tell me again what you would like as a result of coming here?" This questions helps to restate the goal.

"This may sound like a strange question given all that is going on, but how is this a problem for you?" This question can help in obtaining a problem statement from the client.

NORMALIZING:

Solution-focused therapy does not view clients' difficulties as pathological manifestations but rather as ordinary difficulties of life. **Normalizing** clients' difficulties brings the client relief in regards to their situation. Therapists are urged to maximize on every opportunity to normalize struggles. The most common method of normalizing during a session is to say things like, **"naturally"**, **"of course"**, **"welcome to the club"**,

"so what else is new", and, **"that sounds familiar"**, when the client is reporting things they think is unusual or pathological.

Normalizing can also be accomplished in a number of indirect way. **Story telling** about the way your may have struggled with the same difficulties or about other clients' experiences can be helpful to clients. You can also ask the client about a complaint: **does this ever happen?** and proceed to describe the situation. Normalizing can also take place when a distinction is made between a normal developmental task and a pathological description. For example, the therapist may want to ask a question like **"How can you tell the difference between your teenager's depression and normal teenage moodiness?"** Giving clients normalizing compliments for their struggles can help clients to realize that their response to their situation can be normal and appropriate.

After the complaints have been identified and sequences and patterns of behaviours have been explored, the session begins to focus on strengths, resources, tacking down a concrete goal and times when the problem does not exist. The literature on solution-focused therapy, identifies different tools or frames to help the client construct new realities or understanding of their situation. These tools include exception finding questions, goal setting and questions geared to seek out hypothetical solution.

GOAL SETTING:

Solution-focused therapy is an approach that builds exclusively on what the client states she or he wants to change. Although it is the clients' responsibility to **set a goal,** the therapist is active in helping the client establish attainable and concrete enough goals so that we will all know when it has been attained. Given that the therapist focuses on

what the client wants rather than on what the therapist thinks needs to change, **goal setting** becomes crucial to the therapeutic process. The guidelines for well-defined goals as stated in the literature (Berg,1991; O'Hanlon and Weiner-Davis, 1989; Walter and Peller,1992) are as follows:

1) Goals must be small, simple and realistically achievable. Two questions need to be answered: What are you aiming for? What will be a sign that you are achieving the goal?

2) Goals need to be stated in a positive way. That is stated in terms of what the client will be doing or thinking rather than what the client will not be doing or thinking. You are attempting to establish the presence of a positive behaviour rather than the absence. Goals must be described as the beginning of a new behaviour and not the end. If the client describes the goal in a negative manner, use the word "instead" to evoke a positive description.

3) Goals should be stated in a process form or in a movielike description rather than a still picture. A good indication that clients are processing their goal is when the description is made by using action verbs ending in "ing". The description can be based in the present or future tense. The therapist can evoke a process description by asking "how".

4) Goals should be stated in the here and now. The therapist wants the goal to be defined in such a way that the client can be on track to change immediately. We can ask the following question: "As you leave this session and you are on

track to solving this, what will you be doing differently, or saying to yourself differently?"

5) Goals need to be stated as specifically as possible. The therapist's job at this point is to help elicit descriptions by clients of concrete behaviours and what they will they be saying to themselves and to others. For example, ask the questions: "Can you tell me more specifically how you will be doing this? What will your spouse notice specifically that will tell him (her) that you are doing this?"

6) Goals must be within the clients' control. Often clients will request therapists' assistance in changing someone else. Changing another person's behaviour is beyond the clients' control. The therapist can begin to identify goals that can be begun by the client in the counselling session.

7) Goals need to be stated in the clients' language. The therapists needs to be sure they are working towards a goal stated by the clients and not what they think the client needs to change.

In summary, a well-defined goal worksheet designed be Walter and Peller (1991) can be useful as a check sheet.

CRITERIA	KEY WORDS	SAMPLE QUESTIONS
1. In the positive	Instead	What will you be doing instead?
2. In a process form	How	How will you be doing this?

3. The here-and-now	On track	As you leave here today, and you are on track, what will you be doing differently or saying differently to yourself?
4. As specific as possible	Specifically	How specifically will you be doing this?
5. In the clients' control	You	What will you be doing when that happens?
6. In the clients' language	Use the clients' words	

A role play on goal setting will be conducted with participants.

EXCEPTION FINDING QUESTIONS:

The **frame of exceptions** allows the clients to talk about the times when the problem does not occur. Exception finding questions can occur at any time during the interview. Regardless of the magnitude of the problem there are times when the problem does not occur. When exploring the exceptions to the problem information is provided in regards to what is needed to solve the problem. Solutions can be discovered by exploring the differences between times when the problem occurs and times when the problem does not (O'Hanlon and Weiner-Davis, 1989). Exceptions can be behaviours, perceptions, thoughts and feelings that contrast with the complaint and have the potential of leading to a solution if amplified by the therapist and/or increased by the client (Lipchik, 1988). In searching for exceptions, the therapists is in the process of helping

the clients' construct goals by focusing on how they are doing their goal now. Exception finding questions allows the client to recognize that the solution is possible and in the present. Questions geared at seeking exceptions have been developed by O'Hanlon and Weiner-Davis (1989), Walter and Peller (1992) and the Brief Family Therapy Centre in Milwaukee (handouts). The proceeding questions have been borrowed from these three sources:

"Tell me about those times when you act or do a little of that right now?",

"What is different about those times when the exception exist?" (any and all differences between the problematic times and the nonproblematic times are explored),

"Can you think of any other time, either in the past or in recent weeks, that you did not have a problem with...?",

"How do you get that to happen?" (this question is seeking specification so that the client can identify how they contribute to good things from happening so that they can continue to create these changes),

"What's different about the times when this problem doesn't occur?",

"What would you say you do differently at those times?" (this question asked when the client takes an active role in the exception),

"What will have to happen for that to occur more often?" (this question asked when the client takes a more passive position),

"What will you be doing instead when the problem is solved?",

"Have you ever had this difficulty in the past? (If yes) How did you resolve it then? What would you need to do to get that to happen again?".

O'Hanlon and Weiner-Davis (1989), Walter and Peller (1992) and The Brief Family Therapy Centre have also developed relationship exception finding questions. The relationship questions can include children, family members, friends, teachers, probation officer etc. The answer to the exception finding questions can provide clues about what the solution will look like to both the client and their significant others. This line of questioning can also help the client to begin to see a connection between their behaviour and the cessation of a complaint. The relationship questions provide more depth to the description of the exceptions and what part others may play in its solution. These questions include:

"How are you perceived by others as acting differently?",

"If they think you are acting differently, how then do the others act differently with you?",

"If your husband were here, what do you suppose he would say he notices different about you at those times when the problem doesn't happen?",

"What would he say has to happen for that to occur more often?",

"What do you imagine he would say you do differently?",

"What would he say he does different when you are...?",

When the complaint is about the significant other:

"What do you suppose you do different when he doesn't...?",

"What do you imagine he notices different about you when he doesn't...?",

"What would he say has to happen more often for him to continue to...?",

"So, as you continue to do these things, will you think that you are on the beginning of a track to getting what you want out of coming here?" (this question can bridge the exception as a goal of therapy, and frame the goal as continuing to do the exception).

Initially, clients may react very surprised at your line of questioning. This may be due to the fact the clients are in the frame of thinking about their complaint in terms of all and never or that they do not expect therapy to be a place where they will discuss what is going well or right in their lives. Exception seeking questions redirects people's attention on what is different when the complaint does not occur but also to set a stage for clients as to what is important to talk about in therapy.

In some situations, exceptions are very difficult to identify with some clients. Weiner-Davis (1990) suggests that the therapist may do the following:

1. Ask difference questions such as:

   a) what is different about the times when the problem is less intense/frequent/or shorter in duration,

   b) what is different about the times when something good comes out of the problem, and

   c) when clients talk about the complaint pattern ask the question "How did you get the problem to stop".

2. Ask future-oriented or hypothetical questions such as the miracle question or fortune telling questions. A variation of the miracle question can be asked:

"If a miracle happened and you woke up tomorrow and your problem was solved, what will be different?"

If the question is answered, follow-up questions may include:

"are there small pieces of this that are already occurring?" then ask "what do you need to do to make it happen more?"

If the client cannot find exceptions, differences and has no vision of the future without the complaint, the therapist should find out more about the complaint. The therapist is interested in the clients' frame of reference about the problem, how they see the problem, and, the circumstances and the sequence of events when the problem occurs. O'Hanlon and Weiner-Davis (1989) suggests the following questions to obtain a clearer picture of the problem:

"What do you see as the problem? Give me a recent example of it."

In tracing the sequence of events ask:

"What happens?...Then what happens?...After that, what happens?" and keep this line of questioning until you have a clear picture of the pattern.

"Who is present when the problem happens?"

"What does each person say or do?"

"Where does the problem most frequently occur? Least frequently occur?"

"Is there a particular time (of day, month, year) when the problem is (un)likely to happen?"

Once a detailed understanding of the problem is obtained, the therapist will suggest a small change that might make a difference.

A role play on exception-finding questions will take place at this point.

HYPOTHETICAL SOLUTION FRAME:

Hypothetical solution frame is used when the therapist and the clients are having difficulty with a positive framing of the goal, when the client can only see their situation in a problem frame and the therapist cannot find any exception to the problem, or, when the therapist wants to check how the exceptions compare with how the clients imagines the solution to be. The hypothetical solution frame can be found in a number of variations. The Brief Family Therapy Centre in Milwaukee (de Shazer, 1988) developed a "miracle question" which is asked as follows:

> Suppose that one night, while you were asleep, there was a miracle and this problem was solved. How would you know? What would be different? How will your husband know without your saying a word to him about it?. (p. 5)

Through the use of the miracle question, the therapist and client are able to create as clear a picture as possible of what the solution may look like even when the problem is vague and poorly described.

Different variations of the miracle question can be asked. If the client is likely to accept the notion of miracles, Walter and Peller (1991) suggest that the following question can be asked:

> If a miracle happened tonight and you woke up with the problem solved, or you were reasonably confident you were on track to solving it, what would you be doing differently? (p. 78)

This questions presupposes that the problem is solved or on track to being solved.

Some clients will answer the miracle question with a solution that may occur a few months down the road. The miracle question will be asked again, but the emphasis will be **"on a track to solving the problem"** part of the question. Walter and Peller (1991) suggest that the following question can be asked:

> "So, let us say tomorrow you wake up, and you have not decided yet about your situation, but you are thinking you are on track to making an eventual decision, what are you doing differently?"

This question will elicit a response that is more grounded in the here and now. If the client answers the question by talking about how the will feel, acknowledge the feeling and restate the question by asking **"when you feel that way, what will you be doing differently?"**

If the client continues to have difficulty with a solution frame, relationship questions are useful. The following question can be asked:

> "If I were a fly on the wall and watching you, what would I see you doing differently? What would I see that would tell me that you are feeling differently? How would someone in your family know?"

Other questions focusing on relationships developed by the Brief Family Therapy Centre in Milwaukee are as follows:

"What would your partner (parent, child) say would be the first sign that the miracle has happened?"

"The day after the miracle, what would your partner say she/he would notice you do differently? What do you suppose your partner would do differently then? What would your children be doing differently? What else would be different in your household? What would your partner say it would take to make it happen?"

When questioning a younger children, the notion of magic wand is helpful:

"If we had a magic wand and the problem went away, what would you be doing differently?"

Furthermore, the notion of pretending can be used with children:

"Let's pretend the problem is solved and you are having better luck with (the problem), what are you doing differently?"

Some clients will not be able to relate to miracles or magic wands. The following question can be more appropriate:

"If this were the last session and you were walking out of here with the problem solved, or you were at least on track to solving it, what would you be doing differently?"

For the client who is very blaming of former therapists or helpers, ask the question:

"If coming here were useful, what would you be doing differently?"

The proceeding scenarios are not exhaustive of the types of questions one can ask their clients. The important piece is to take into account the clients' worldview and their beliefs to help them enter the hypothetical solution frame. It is important to be patient with clients' reaction to the questions asked for this may be a new form of questioning they are not accustomed to. Clients may respond by saying "I don't know" which is acceptable. Insoo Berg developed a question to this response which sounds comical at first glance but produces useful responses:

"So, if you did know, what might you say?" (Walter and Peller, 1991, p. 81).

The responses received from the hypothetical solution questions need to be measured against the criteria for a well-defined goal discussed previously. The therapist will bring the hypothetical solutions into the present and question the client as to when the solutions are happening now. The advantage of identifying the solutions as occurring in the present is that the goal of therapy can then be framed as **"keeping this going"** rather than as "solving the problem". Another advantage of bringing the hypothetical solution in the present is that clients will start to use language which will orient them to the present and have them become actors of change as they speak. Often, the miracle question can help clients to find exceptions they could not find before. Questions used to bring the hypothetical solutions into the present are as follows:

"So tell me about some times when the hypothetical solution may be happening a little now?", or

"How often does that happen now? How do you do it?", or

"Tell me about the times now when you have more of the perspective that you are looking for?", or

"What would you have to do so that it would happen more often?"

SCALING QUESTIONS AND COPING QUESTIONS:

Scaling questions and coping questions are other therapeutic tools used during the session.

Scaling questions can be used to assess the client-therapist relationship, level of motivation and commitment to the change process, progress in therapy, prioritization of the things needed to be done, and, level of hopefulness that changes will occur.

Scaling questions are simple and versatile. They can be used with children who understand that five is less than ten. They can also be used when the problem is unclear or when there is disagreement about the problem. Scaling questions help make things more concrete, change and progress easier to see and to measure. Scaling questions have been developed by the Brief Family Centre in Milwaukee. They are limitless. Here are a few examples:

"On a scale of one to ten, with ten meaning you have every confidence that this problem can be solved, and one meaning no confidence at all, where would you put yourself today?" "On the same scale, how much chance do you give yourself that this problem can be solved?" The closer the response to ten, the more confidence the therapist can have that the client is wanting to work on the problems.

"On the same scale, how much would you say you are invested in solving this problem? How much is your partner invested in solving the problem? How do you account for the differences? What do you know that she/he doesn't know?"

"When the figure on the scale is improved by one point, what will be going on in your life that is not going on now?"

When working with clients who cannot be comforted or reassured, **coping questions** can be very useful. They are empowering and can be uplifting. The goal is to help the client find their own resources and strengths. The coping questions involve the following:

"This problem sounds incredibly difficult, how have you survived? How have you coped? What have you been doing to take care of yourself?"

"What would other people say you've been doing to cope or survive?"

THINK BREAK:

After forty-five minutes to an hour, the therapist is encouraged to take a **think break**. The client is informed that the therapist will take a break. The break involves taking some distance and time from the session so that the therapist can prepare direct feedback for the client. During this time the therapist, either alone or with a consultation team, will focus on the things that the client is doing that is positive and helpful. The focus is on solutions, exceptions, reframes or metaphors the client expressed during the session. The feedback given will be organized around giving the client compliments, messages about our impressions and a possible task. The break can also be a time for the

client to reflect on the session and the possible questions raised during the session. The break is of a five to ten minute duration.

COMPLIMENTS AND INTERVENTION MESSAGE:

After the break, the therapist will deliver the **compliments and intervention message**. The feedback given to the clients is positive. The central idea of giving compliments is to facilitate the solution process. Walter and Peller (1991) describes seven ways that the compliment will facilitate building further on solutions:

1) Compliments provide a positive climate. The client will generally relax and you will see the clients nodding in agreement to what is being said. Clients may also mention how the compliment is a new way of looking at things. At this time the client may offer their thoughts and the exceptions they have had time to realize during the break.

2) Compliments highlights recent changes. The compliments will facilitate continued changes by pointing out what the client is already doing that is helpful or working. Then list all the exceptions to the problem and the recent changes that were described during the session.

3) Compliments alleviates the fear of judgement. The client will leave the session knowing what the therapist thought of the session. Many clients fear that the therapist will be critical but the compliments dismisses this fear.

4) Compliments alleviates fears about change. Clients may be fearful of the consequences of change or being told they have failed and need to do so much more to

change their situation. Compliments can be empathetic and supportive as they let clients know that the therapist understands.

5) Compliments normalizes clients' situation. Compliments can be stated in such a way that the problem is described as common, or expected, and that there is nothing wrong with them. Normalizing can have the effect of allowing clients to stop blaming themselves, or someone else, and then do something different.

6) Compliments can enhance clients' responsibility taking. Compliments provides the opportunity to remind the client that the credit for change lies within them and their control. We want to minimize as much as possible any credit the client may give to the therapist for their changes. By shifting the locus of responsibility onto the client, they will be more able to look within themselves to find the resources to tackle any problem that may arise instead of depending upon therapy.

7) Compliments are used to support many point of views. Compliments are given to each member present during the session. By complimenting everyone, the therapist acknowledges everyone's view and this can demonstrate that many views can coexist.

The second part to the feedback given to the client is the **intervention message** and it has four purposes (Walter and Peller, 1991).

1) The message can be educational. Messages carrying within them statements about research or expert opinions can help the client to think about their situation differently, or, support what the client already believes or is doing.

2) The message can be normalizing. We may want to affirm and normalize what clients are doing by acknowledging their efforts.

3) Messages can give alternative meanings to the client about what is happening. This new meaning will be framed by using positive language.

4) Messages are a rational for a suggested task. The task is thus framed by the message and put within a context.

THERAPIST-CLIENT RELATIONSHIP PATTERNS:

Therapist-client relationship patterns are very important when considering the type of task to give to the client. The Brief Family Therapy Centre in Milwaukee (de Shazer, 1988) have described three types of therapist-client relationships: visitors, complainants and customers. These categories are just guidelines and not all client-therapist relationships are this clear cut. If you are not sure, it is best to take a conservative approach in the interventions given to clients.

Some clients (visitors) come to therapy without any complaints they can perceive but were told to go or were brought in by someone. In this situation, the person with the complaint may not be present in therapy. With **visitors,** therapy cannot begin because there is no complaint. Any intervention will be rejected. With the visitor, the therapist gives the client a great deal of positive feedback for what is going right in their lives but no tasks are given. At times, the following session may bring in complaints and the opportunity to goal set with the client.

Complainants are very good at describing their complaint. By the end of the assessment phase with a complainant, there is the beginnings of a goal and some expectation of change. However, the client is not committed to take the steps to solve

the problem. In intervening with the complainant, the therapist would be advised to give only thinking and observational tasks.

Customers are clients who indicate that they are willing to do whatever it takes to change the complaint. They, along with the therapist have begun to define goals and solutions to the complaint. Customers also become aware that solutions are their responsibility. Since the client is wiling to take steps, interventions may include behavioural tasks as well as to monitor the differences.

TASKS:

Tasks or homework assignments flow from the session and are meant to build on solutions which were begun in the session. Some tasks are intended to interrupt the complaint pattern while others are meant to build on pre-existing solutions or strengths.

The Brief Family Therapy Team at Milwaukee (de Shazer and Molnar, 1984) designed a **first session formula task.** It reads as follows:

> Between now and the next time we meet, we (I) want you to observe, so that you can tell us (me) next time, what happens in your (life, marriage, family, or relationship) that you want to continue to have happen. (p.298)

Walter and Peller (1991) have tailored this task so that it fit their needs better. Their **"observe for positive task"** reads as follows:

> Between now and the next time you come in, we would like you to look out for those times when there is some harmony in the family and take note of what you

> and everyone else are doing. It seems you must be doing something right at those times and we would like to know more about what that might be. (p. 126)

The above two interventions are meant to show the clients that the therapist expects something positive to happen or to continue happening. Often the client is not expecting this type of a task. The two tasks lets the client know that the therapist expects changes in a situation which the client may have viewed as being stagnant.

The therapist will open the following session with this question: **"So, what happened that you want to continue to have happen?"** The therapist will respond to any comment with questions like **"That seems different"** or **"That seems like a change from before"**. The therapist's solution language portrays that a change was expected and that it was noticed by the client. The therapist will pursue the questioning by asking: **"is this change connected to your goal?"**

O'Hanlon and Weiner-Davis (1989) describe a second task that can be given to clients. They have named this task the **"Surprise task-for couples or for families":**

> Do at least one or two things that will surprise your parents (spouse, if doing marital therapy). Don't tell them what it is. Parents, your job is to see if you can tell what it is that she is doing. Don't compare notes; we will do that next session. (p. 137)

The clients are asked to notice changes in behaviour. The following session, the therapist will ask the parent what did you notice your child doing this week? What did

you notice your parents doing this week? Often the surprise behaviour develops into solutions.

Another task, **"do more of the positive or exceptions when these are perceived as deliberate and within the clients' control"** (Walter and Peller, 1991), is given to clients when the session produced exceptions to the problem or when changes have already been recognized and as being within the clients control. The therapist instructs the client to continue doing the exceptions and to observe what happens. This task fits along the lines of the **"generic task"** given by O'Hanlon and Weiner-Davis. For example, if the client wants to have more control, the therapist suggests to the client "to keep track of what you are doing this week that makes you feel more in control.

If the client can report exceptions but sees their occurrence as outside of their control, a task that focuses their attention on how the exceptions are being accomplished is suggested. Walter and Peller (1991) state that the task may involve asking the client to pretend:

> We suggest that on odd numbered days of the week you pretend to feel different and see what happens and on even numbered days just do as you normally do. Let us know what differences you notice. (p. 131)

de Shazer and Molnar (1984) suggest another task for clients who think the exception is being beyond their control. They suggest to clients the **"pay attention to what you do when you overcome the urge to (perform a behaviour associated with the complaint)"** task.

A **"do something different task"** is given to clients when a client complains about a sequence of events that repeats themselves. This task allows client to experiment with changes of behaviour as the pattern is repeated. This task also promote random behaviours in clients. The client is then asked to pay attention to what is different when they do something different.

Viewing the Milwaukee tape will take place at this point in the workshop. This will be followed by a group exercise on designing compliments, intervention message and tasks which is suggested in the Milwaukee tape. Afterwards, a big group discussion will occur during which each small group will report their discussion about the think break.

SUMMARY OF THE FIRST SESSION

Joining:

Pay attention to language, metaphors and verb tenses.

Description of the complaint:

Hear the client's complaint.

When did the complaint begin? How have they tried to resolve the complaint?

Listen for the client's perception and meanings given to their situation.

Goal setting:

Answer the question: How will you know when you don't have to come back?

Keep the six criteria for a well defined goal in mind.

Exceptions:

Get a description of what it is like when the complaint is not happening.

Explore whether there are times when their goal is already happening.

Scaling questions:

Use scaling questions for a variety of exploration: ie. scaling client's confidence, motivation, behavioural description of changes.

Hypothetical or future-oriented frame:

Miracle question to further understand their future vision without the complaint.

Use future-oriented vision to determine exceptions.

Compliments:

Encourages a "yes set".

Intervention message:

Helps to normalize and further provide information to the client.

Tasks/suggestions:

Remember to give tasks that seem appropriate for the client.

A copy of the first session will be given to participants.

Subsequent sessions:

In solution focused therapy, the duration of the therapy is unpredictable. The client will tell the therapist through their actions and feedback what is needed and whether or not another session is necessary. Every session is approached as being the first and as being the last.

Each session after the first begin with the question **"So tell me what is different or better?"** This question presupposes change or at least that something may be different.

With some clients they will come into the second session with a number of reported changes. By the end of this session, a clear picture of the changes has been obtained, how this occurred and what is needed to have the changes continue. During this session the therapist may want to flag the minefield. If the client sees a challenge within the next few days, ask **"what would the challenge be?"** Discuss the challenges fully with the client.

Once distinctions between exceptions and the complaint has been made, the therapist can execute a number of techniques which can further build on and maintain

what the client is doing that is goal and solution oriented. Kral and Kowalski (1989) have identified six approaches and they include: 1) cheerleading, 2) positive blame, 3) betting on whether or not the desired changes will continue, 4) identifying the new context, and, 5) flagging the minefield.

Cheerleading involves giving the clients support and encouragement for the positive things they are doing especially the changes and differences noted. Acknowledging change as soon as they are mentioned is important, no matter how small changes may be. Cheerleading can be used in conjunction with another approach.

Positive blame is an encouragement which presupposes that the client has control over their situation and are responsible for implementing changes. However, at times, clients believe that the changes have been either out of their control or a spontaneous occurrence. Questions that will assist the clients to think that they had more control over their changes can include:

"How did you decide to do that?"

"How do you explain that?"

"That is great"

If the client begins to say "yes, but" you need to do something different. Chances are you are ahead of the client and may need to scale down your encouragement.

Betting has proven to be a powerful tool especially with children, adolescents or adults who are competitive (Kral and Kowalski, 1989). The client is challenged with a bet relating to the continuation of an identified change. This method requires that the client can both describe the new behaviour in concrete descriptions and have the

confidence that the new pattern of behaviour will continue. Betting works well when a team is involved in challenging the client and the therapist can take the clients' side.

New context represents the description of behaviours which need to be present for the changes to continue. The question **"what needs to happen for the desired behaviour to happen more often or again?"** is a context marker.

Flagging the minefield is an approach used to help identify factors which could result in old patterns of behaviour to resurface. This technique allows the client to acknowledge that there is a differentiation between the now, symbolized by new behaviours and the old ways which are now part of the past. Flagging the minefield can also normalize for the client that set-backs can occur. Challenge in detail and then ask **"How will you handle it differently this time?"**

For other clients, after the question "So tell me what is different or better?", begin to discuss the difficulties they experienced since the last session. When this begins, the therapist will want to redirect the session by interrupting the client and saying that you will get to that part, but at this time you want to hear about the differences. Once the positives have been explored, the therapist can ask what the concerns might be. As in the first interview, you will get a description of the problems and ask questions to sort out the exceptions. Scaling questions can be useful with this group of clients. They will assist in obtaining a better understanding of the steps the client can take in order to get on track.

When the client reports that things are the same or even worst, accept what they say as their view of the situation, but the task of the therapist is to ask exception finding

questions to find any differences in how they handled the situation. If the situation is reported as worst, revisit the stated goal to ascertain this remains the working goal and then use the hypothetical solution frame, such as asking **"Are there actions or words that you would do differently if you had a week to do over again?"**

All the tools used during the first interview will be used in subsequent interviews.

If therapy is not progressing in any way, the therapist need to reconsider the following:

Who is the customer? Who is complaining about something? Who wants to change? Who perceives a problem?

What is the goal? How will we know when we get there? Is the goal well-defined?

Are you and the client looking for too ,much too fast?

Are you asking clients to do tasks that they are unwilling to do? Remember if it does not work, do something different.

Are you repeating former therapists ineffective approaches? Repeating what your client has unsuccessfully been doing to solve the problem? Repeating well-meaning advice given by friends and family but rejected by the client?

Are you attending to the client's responses and messages to you?

Viewing a tape on a subsequent interview will take place at this point in the workshop. A role play on a subsequent interview will follow.

APPENDIX C

PARTICIPANT DATA FORM

PARTICIPANT DATA FORM

1. Name________________________ Phone Number________________
2. Place of employment ______________________________________
3. Position held at place of employment: area in which you are presently working
   ____
4. Gender M____ F_____ 5. Year of graduation____________

6. Work experience in Human Services:
   - less than 1 year _______
   - 1-2 years _______
   - 3-5 years _______
   - More than 5 years _______

7. Work experience in your present work place:
   - less than 1 year _______
   - 1-2 years _______
   - 3-5 years _______
   - More than 5 years _______

8. Educational background:
   - BSW _______
   - MSW _______
   - BA _______
   - MA _______
   - Other(specify) _______

9. Which of the following clients do you work with:
   - Individuals _______
   - Families _______
   - Couples _______
   - Groups _______

10. Do you typically work with clients:
    - Less than 5 sessions _______
    - 5-10 sessions _______
    - More than 10 sessions _______

11. Have you done reading about Solution-focused approach?
    Yes _______ No _________

12. Have you obtained previous training about Solution-focused approach?
    Yes _______ No _________

APPENDIX D

PARTICIPANT FEEDBACK FORM

PARTICIPANT FEEDBACK FORM

Name____________________

This form asks you to reflect on your knowledge and attitude about solution-focused therapy before and after the training program. Your responses to the questions are confidential. Thank you very much we appreciate your cooperation.

Please circle the number on the scale which best represents your answer.

1. (a) Thinking back to where you were **before** the training session, to what extent did you believe it was important to focus on solutions in working with clients?

1	2	3	4	5
Not At All		Some of the Time		To a Great Extent

(b) **Now** that you have received training in solution-focused therapy,to what extent do you believe it is important to focus on solutions in working with clients?

1	2	3	4	5
Not At All		Some of the Time		To a Great Extent

2. (a) Thinking back to where you were **before** the training session, to what extent did you believe it was important to work at changing clients' problem-centered view of their situation to one which is more solution-focused?

1	2	3	4	5
Not At All		Some of the Time		To a Great Extent

(b) **Now** that you have received training in solution-focused therapy, to what extent do you believe it is important to work at changing clients' problem-centered view of their situation to one which is more solution-focused?

1	2	3	4	5
Not At All		Some of the Time		To a Great Extent

3. (a) Thinking back to **before** the training session, to what extent did you believe you had to have detailed knowledge about the complaint in order to resolve it?

1	2	3	4	5
Not At All		Some of the Time		To a Great Extent

(b) **Now** that you have received training in solution-focused therapy, to what extent do you believe you have to have detailed knowledge about the complaint in order to resolve it?

1	2	3	4	5
Not At All		Some of the Time		To a Great Extent

4. (a) Thinking back to **before** the training, to what extent did you believe rapid change was possible?

1	2	3	4	5
Not At All		Some of the Time		To a Great Extent

(b) **Now** that you have received training in solution-focused therapy, to what extent do you believe rapid change is possible?

1	2	3	4	5
Not At All		Some of the Time		To a Great Extent

5. (a) Thinking back to **before** the training session, how knowledgeable were you about the concept of exceptions?

1	2	3	4	5
Not At All		Some of the Time		To a Great Extent

(b) **Now** that you have received training in solution-focused therapy, how knowledgeable are you about the concept of exceptions?

1	2	3	4	5
Not At All		Some of the Time		To a Great Extent

6. (a) Thinking back to **before** the training session, did you know how to move clients into a hypothetical or future-oriented frame in order to explore their perception of what they want changed or resolved?

1	2	3	4	5
Not At All		Some of the Time		To a Great Extent

(b) **Now** that you have received training in solution-focused therapy, do you know how to move clients into a hypothetical or future-oriented frame in order to explore their perception of what they want changed or resolved?

1	2	3	4	5
Not At All		Some of the Time		To a Great Extent

7. (a) Thinking back to **before** the training session, did you know how to assist clients in defining clear goals which are descriptive, behavioural and focused in the here and now?

1	2	3	4	5
Not At All		Some of the Time		To a Great Extent

(b) **Now** that you have received training in solution-focused therapy, do you know how to assist clients in defining clear goals which are descriptive, behavioural and focused in the here and now?

1	2	3	4	5
Not At All		Some of the Time		To a Great Extent

8. (a) Thinking back to **before** the training session, how knowledgeable were you with the concept of the intervention breaks?

1	2	3	4	5
Not At All		Some of the Time		To a Great Extent

(b) **Now** that you have received training in solution-focused therapy, how knowledgeable are you with the concept of the intervention breaks?

1	2	3	4	5
Not At All		Some of the Time		To a Great Extent

9. (a) How knowledgeable do you think you were about solution-focused therapy **before** the training session?

1	2	3	4	5
Not At All		Some of the Time		To a Great Extent

(b) How knowledgeable do you think you are about solution-focused therapy **since** the training session?

1	2	3	4	5
Not At All		Some of the Time		To a Great Extent

10. (a) How likely do you think you were **before** the training session to use solution-focused therapy?

1	2	3	4	5
Not At All		Some of the Time		To a Great Extent

(b) How likely do you think you are to use solution-focused therapy **now** that you have participated in the training session?

1	2	3	4	5
Not At All		Some of the Time		To a Great Extent

APPENDIX E

PARTICIPANT SATISFACTION QUESTIONNAIRE

PARTICIPANT SATISFACTION QUESTIONNAIRE

Please help us improve our training program by filling out this questionnaire. Please circle the number that reflects your opinion about the training program and your facilitator. Thank you very much, we really appreciate your cooperation.

1. How would you rate the quality of training you have received?

4	3	2	1
Excellent	Good	Fair	Poor

2. Did you get the kind of training you wanted?

1	2	3	4
No Definitely	No Not Really	Yes Generally	Yes Definitely

3. If a colleague were wanting similar training, would you recommend our program to him or her?

1	2	3	4
No Definitely Not	No I Don't Think So	Yes,I Think So	Yes Definitely

4. In an overall, general sense, how satisfied are you with the training you received?

4	3	2	1
Very Satisfied	Mostly Satisfied	Indifferent or Mildly Dissatisfied	Quite Dissatisfied

5. If you were to seek training again, would you request service from Family Centre of Winnipeg?

1	2	3	4
______	______	______	______
No Definitely Not	No I Don't Think So	Yes,I Think So	Yes Definitely

ABOUT THE FACILITATOR:

6. How would you rate your facilitator?

4	3	2	1
______	______	______	______
Excellent	Good	Fair	Poor

7. Were you satisfied with your facilitator's concern for your learning?

4	3	2	1
______	______	______	______
Very Satisfied	Mostly Satisfied	Indifferent or Mildly Dissatisfied	Quite Dissatisfied

8. Was the facilitator prepared?

1	2	3	4
______	______	______	______
No Definitely	No Not Really	Yes Generally	Yes Definitely

9. Did the facilitator hold the interest of the group?

1	2	3	4
______	______	______	______
No Definitely Not	No I Don't Think So	Yes,I Think So	Yes Definitely

10. Was the facilitator dynamic and enthusiastic?

1	2	3	4
____________	____________	____________	____________
No Definitely Not	No I Don't Think So	Yes,I Think So	Yes Definitely

11. Was the material presented in a clear manner?

1	2	3	4
____________	____________	____________	____________
No Definitely Not	No I Don't Think So	Yes,I Think So	Yes Definitely

12. Did you feel the subject was adequately covered?

1	2	3	4
____________	____________	____________	____________
No Definitely	No Not Really	Yes Generally	Yes Definitely

Adapted from Client Satisfaction Questionnaire: Copyright(c) 1978, 1985 Clifford Attkisson.