WHAT WORKS WHEN LEARNING SOLUTION FOCUSED BRIEF THERAPY: A QUALITATIVE ANALYSIS OF TRAINEES' EXPERIENCES

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(ABSTRACT)

With its growing popularity in the field, Solution Focused Brief Therapy (SFBT) training workshops are becoming more prevalent in the family therapy training field. Because SFBT represents an innovative approach to therapy, does teaching this model demand innovative ways to train its students or are the same methods used in teaching other models of family therapy sufficient? To begin to address this question, it would be important to know how trainees experience SFBT training as it currently exists. This study qualitatively examined the process that trainees experienced when learning SFBT. Fifteen individuals responded to an email questionnaire, with 7 of those individuals participating in follow-up telephone interviews. In summary, being able to practice using a solution focused approach with clients and receiving supervision on those sessions from a supervisor who used a solution focused framework in giving feedback were factors identified as being most helpful in facilitating the learning process. The study also examined how the participants merged their existing beliefs about people and the therapeutic process with the assumptions inherent to SFBT. Finally, the study examined distinct moments, defined as moments after which the trainee knew that SFBT was a model they could use effectively with their clients. The distinct moments provided a picture of how the training and learning came together in practice for the participants.

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CHAPTER 1: INTRODUCTION

There is increasing evidence that marriage and family therapy (MFT), in general, is a useful approach that can be used with a variety of problems (Shadish, et al, 1995). With increasing evidence that MFT can be helpful, the question of how to train therapists to deliver this modality arises. However, a review of the literature reveals that research on MFT training and supervision is an area that remains largely underdeveloped (Hawley, Bailey and Pennick, 2000). The existing studies have been able to address some of the general principles of training and supervision, however, research detailing the process by which training and supervision occur are needed (Anderson, Rigazio-Digilio and Kunkler, 1995). MFT is a collection of different models, which may present different challenges in regards to training and supervision. Newer models, such as Solution Focused Brief Therapy, would be especially useful to examine, given its growing acceptance in the field. This study will begin to examine and explore the training experiences specific to Solution Focused Brief Therapy.

Solution Focused Brief Therapy

When a client steps into a therapy room, older approaches to therapy, such as the psychodynamic approach, would have the client talk about the past where the roots of the problems affecting the client now are assumed to be found. In the 1960s, the family therapy field saw a shift from past-oriented thinking to present oriented thinking. Less emphasis was placed on learning the history of a client's problems. Instead the therapist focused on how the client was handling his problems presently and what behaviors seemed to be maintaining the problem.

The model of Solution Focused Brief Therapy (SFBT), as developed by Steve de Shazer, Insoo Kim Berg and others at the Brief Family Therapy Center in Milwaukee, Wisconsin, represented a further shift to future-oriented thinking. deShazer (1985) used the metaphor of looking at the client's complaints as a lock on the door. Examining the lock will not lead to it unlocking. However, finding a key that will open the lock will more successfully lead one to a solution (deShazer, 1985).

There are a number of assumptions that form the philosophies underlying SFBT and that distinguish it from other approaches. First, there is the belief that change is constant, which would suggest that the complaints the client brought in are unlikely to

persist. deShazer (1985) described complaints as being behaviors derived from the client's perception, which unlike the complaints themselves, is likely to remain constant. By making changes in one's perception, new behavior based on the new perception can help promote a resolution to the client's complaints. Another important assumption is the idea that some pieces of the solution, or exceptions to the problem, are already present in the client's life. Focusing on these exceptions that are already present, rather than the aspects of the problem, will more likely lead to resolution of the client's complaints. By expanding the pieces of the solution that are already present, the theory follows that these pieces will begin to overshadow the complaint that the client has brought in.

SFBT also represents a shift in the role of the therapist. While more problem-focused approaches have the therapist taking on an expert role, in SFBT, the therapist and client develop a collaborative relationship, as the client is seen as the authority on what works best in handling their problems. Since the client is seen as the expert of their own situation, SFBT has the client formulate their own goals for therapy. It is the therapist's job to guide the client toward those goals, by helping them envision a future in which their problems no longer exist and amplify the changes the client is already making.

Additionally, a number of interventions are associated with SFBT and take the form of specific questions the therapist can ask to help the client envision a place where problems no longer exist as well as see how parts of the present situation already fit into that vision. One of those techniques is searching for pre-session change, in which the therapist questions the client during the first session about what changes have happened since the time they scheduled the initial appointment and when they came in for the first appointment. Highlighting these changes indicate to the client that they are capable of making changes on their own. Scaling questions ask the client to pinpoint on a scale of one to ten, where ten represents their stated goal, where they are currently in relation to reaching their goal. Use of this technique gives the therapist an idea of how the client views their situation. Follow up questions by the therapist would include asking the client what they could do to move one step higher on the scale. Exception questions ask the client about the details of the times in their lives when the complaint is not occurring and what the client was able to do differently during those times (O'Hanlon and Weiner-Davis, 1989).

Perhaps the most known of the SFBT techniques is the miracle question, which in its basic form poses the scenario of a miracle happening for the client, in which the problem with which they are seeking help, is solved. The interesting part of this scenario that is presented to the client is that the miracle happened while the client was sleeping, and subsequently asks the client how they would know that the miracle had occurred. The responses to the miracle question help the client begin to create a picture of what their life would look like without the problem (O'Hanlon and Weiner-Davis, 1989).

There have been several research studies conducted regarding the effectiveness of SFBT. Gingerich and Eisengart (2000) reviewed fifteen controlled outcome studies of SFBT to examine the effectiveness of this approach to therapy. To be included in this review, a study had to employ an experimental design, measure client functioning, and assess treatment outcomes. The study also had to use interventions identified by the authors as being solution focused, meaning the intervention had to include at least one of seven SFBT components, which differentiate it from traditional therapeutic interventions. Although fifteen studies were reviewed, only five were considered well-controlled. The five well-controlled studies showed SFBT as providing a significant benefit. Additionally, although no firm conclusions could be drawn about the remaining ten studies because of their methodological problems, these studies also showed the effectiveness of SFBT. While they could make no definitive statement regarding the overall efficacy of SFBT, Gingerich and Eisengart concluded that these studies support the idea that SFBT can be beneficial to clients.

Gingerich and Eisengart did note that one of the limitations of the literature was the lack of standardization regarding the implementation of SFBT. They noted that, of the studies they reviewed, only two contained all seven components of SFBT. Five of the studies contained four or fewer components. It seems the statement that SFBT can be beneficial to clients can be accurately made only if it can be determined what components of SFBT are actually being delivered. The definition of SFBT would need to be standardized in order to generate definitive outcome research.

Since its introduction in the therapeutic field, it appears that many practitioners have embraced SFBT as a new and innovative way of working with clients. A review of the literature indicates that SFBT has been used with several different populations

presenting with several different types of situations in several different settings. In particular, SFBT has been used in treatment approaches when working with such difficult issues as domestic violence (Lipchik and Kubicki, 1996), substance abuse (Osbourn, 1997), severe abuse victims (Dolan, 1994) and juvenile offending (Clark, 1996). With its growing popularity in the field, SFBT training workshops and classes are becoming more prevalent in the family therapy training field. With that in mind, it would appear to be beneficial for both trainers and trainees to become familiar with this model, especially how SFBT is taught and what is most helpful in learning how to use this model effectively. But since SFBT is a new approach, which differs from other models of doing therapy, in theory and in practice, does this model also demand a new style of training or would the training methods used to teach other models of therapy suffice?

Statement of the problem

Much of the existing research on family therapy training up to this point has focused on what skills should be taught to trainees and how those skills should be taught (Maynard, 1996). Other areas that prior research seemed to focus on are the effectiveness of training, the development of instruments to assess clinical development and the impact of training on skill development and clinical outcomes (Bischoff, 1997). One theme that developed in the literature on family therapy training and supervision is the concept of isomorphism, which refers to the idea that the patterns and content of a family therapy model are replicated in the training and supervision of that model (Liddle, Breunlin, Schwartz and Constantine, 1984). As such, each model of family therapy will have different approaches to training with those training approaches reflecting the theoretical framework of that particular model of family therapy as well as the theoretical framework of the trainer/supervisor. Since SFBT is an approach that departs theoretically from other family therapy models in practice, it would be important to explore whether SFBT is learned and taught in the same manner as other family therapy models. To begin to explore this, it is important to know how trainees experience SFBT training as it currently exists.

Becoming a family therapist can be a complex process, requiring not only learning theories and developing therapeutic skills, but also developing one's confidence, addressing personal issues, and integrating new knowledge with one's prior experiences

and philosophies. What appears to be lacking in the area of family therapy training research are studies that can provide some information and insight into the trainees' experiences and the processes they go through as they learn to become family therapists. Research focusing on these issues can offer an opportunity for trainees to voice their perspective on what they found to be most or least helpful in their training experiences. It can also provide feedback to trainers so they can further improve and enhance their training methods.

The purpose of this study was to qualitatively examine the process that trainees experience when learning SFBT as an approach to therapy. Specifically, what training methods and aspects of the training environment seem to be helpful when learning SFBT? This study also asked trainees about their own beliefs and philosophies concerning people and their problems and how these fit (or do not fit) with the philosophies underlying SFBT. Since the participants in this study were the trainees of individuals who learned this model from its original developers, one could assume that the SFBT they are learning and practicing is a purer, more standardized form of this model. Since the participants in this study were also individuals, who are defined by their trainers as successful adopters of this model, some information about what happens when this learning process is successful can be obtained. This study could inform the practice of family therapy in that by examining these areas, some initial conclusions about how best to learn this model may be drawn.

Theoretical framework - Phenomenology

The theory that informs the study is phenomenology, which was defined broadly by Deutscher in 1973 as "understanding the social actor's frame of reference" (cited in Boss, Dahl and Kaplan, 1996, p. 83). The use of phenomenology involves the understanding that each individual has his/her own idea of what the "truth" is in any given situation or circumstance. This type of research is therefore not so concerned with the facts and details of a situation as it is with the meaning assigned to that situation, the underlying structures of those meanings and how those structures are reinforced (Boss et al., 1996).

Along with that understanding comes the idea that several people can experience the same situation and each assign a different meaning to it (Boss et al., 1996).

Therefore, although several trainees are learning about SFBT and the philosophy and interventions associated with it, each trainee may perceive the material in different ways and therefore assign different meanings to what he/she is learning and how they can apply that in their work. In the same vein, each trainee will bring his/her own experiences and prior knowledge, which may affect how they learn SFBT and how they integrate that new knowledge with their existing knowledge.

Phenomenology also understands the researcher to be on equal, if not subordinate, ground with the subjects being studied. In other words, it is the trainee, not the researcher, who is seen as the expert on their situation (Boss et al., 1996). This line of thinking is similar to the philosophy that underlies SFBT. The trainee's definitions and language are important to consider when making inquiries about their experiences. In doing that, any pre-conceived assumptions about the trainee's experience could be avoided.

Research questions

I focused on two main questions in order to gain a better understanding of the process involved in learning SFBT. First, what were the trainees' experiences in learning SFBT; specifically what training methods did they find most helpful when learning this model and what factors in their training environment seemed to facilitate their learning process? Secondly, what was the process the trainees experienced in fitting their own personal philosophies with those underlying SFBT?

CHAPTER TWO: LITERATURE REVIEW

The purpose of this chapter is to provide relevant background information to this study. The first section of this chapter will provide an overview of Solution Focused Brief Therapy (SFBT), including the definition and history of this model of therapy and how it is distinct from other models of therapy. This section will also this model's use with different populations, research on SFBT and its outcomes, and issues identified as future areas of research.

The second section of this chapter will provide an overview of marriage and family therapy (MFT) supervision, including a discussion of MFT training and supervision methods and modalities. This section will also describe and discuss SFBT training and supervision. A summary of the literature on training issues from the trainer/supervisor perspective as well as the trainee/supervisee perspective will also be included. Finally, this section will discuss issues identified as future areas of research regarding family therapy training and supervision.

Definition and History of Solution Focused Brief Therapy

Solution Focused Brief Therapy (SFBT) developed from the work of Steve deShazer, Insoo Kim Berg and others at the Brief Family Therapy Center in Milwaukee, Wisconsin. SFBT is similar to other brief therapy models in that it works toward attaining specific behavioral goals and does not focus on obtaining information about the client's history (Nichols and Schwartz, 2001). Where SFBT differs from other brief therapy models is its focus on what the client is already doing to resolve the problem they have brought into therapy. This approach also focuses more on the client's competencies and strengths rather than their deficits and weaknesses (O'Hanlon and Weiner-Davis, 1989).

deShazer was primarily influenced by the work of Milton Erickson as well as his own tenure at the Mental Research Institute in Palo Alto, California. Erickson's problem/symptom focus was different than other therapists of his time, who saw symptoms as reflections of deeper psychic problems. Erickson also viewed the client as having the resources and strengths to solve their problems and he worked toward the goal of tapping those resources. The Mental Research Institute espoused brief therapy that worked toward specific behavioral goals. When those goals are reached, then therapy is

concluded. Largely a behavioral model, its interventions targeted problematic patterns in a family, and worked to help the family change the patterns altogether or reframe the family's perception of the problem, which in turn would affect behavior (Nichols and Schwartz, 2001).

Combining the brevity of the work at the Mental Research Institute and the strength-based work of Milton Erickson, deShazer developed SFBT. The primary goal of SFBT is to resolve the presenting problem of the client by amplifying exceptions to the problems, or times that the client is not experiencing the problem, and identifying the client's resources that are not being used toward the resolution of the problem. The role of the therapist is better described as collaborator rather than expert, with the client establishing the goals of treatment. Solution-focused therapists believe that there is no absolute definition of what can be considered normal, and therefore do not impose their own beliefs on their clients (Nichols and Schwartz, 2001).

As one of the therapy models of the postmodern era, SFBT relies heavily on the idea that there is no absolute truth. SFBT is also based on the ideas of constructivism, which "asserts that reality doesn't exist as a 'world out there' but, instead is a mental construction of the observer" (Nichols and Schwartz, 2001, p. 310). With the idea that there is no absolute truth and a person's reality is constructed in large part by their perception and language used to describe their reality, the use of solution-focused language is an important piece of SFBT. This is a piece that also distinguishes SFBT from other models of family therapy. Use of solution focused language means the therapist assumes that the client is already taking steps to solve their own problems. Therefore, a solution-focused therapist will question the client on *when* they are making changes and employing solutions, rather that *if* they are making changes and employing solutions.

As one of the brief therapy models, SFBT prides itself on being able to effectively and quickly address the complaints that clients bring into session. In a study conducted at the Brief Family Therapy Center in Milwaukee, Wisconsin, 72% of their cases (a randomly selected 25% of 1600 cases seen from 1978 through 1983) reported improvement within an average of six sessions per client (deShazer, 1985). deShazer asserts that brief therapy is not merely "less of the same" (p. 4), but rather realizes the

importance of making the most of the average length of treatment (6-10 sessions). He states the importance of building a model based on the reality that a client is more likely to experience a shorter number of sessions, rather than an ideal unlimited number of sessions (deShazer, 1985).

Throughout the course of therapy, the solution-focused therapist continues to highlight exceptions to the client's problems, and reinforces changes that have taken place through giving compliments or directly attributing the changes to the client's behavior, by asking the client how they were able to do something differently (Kral and Kowalski, 1989). The techniques associated with SFBT, some of which are described in Chapter 1, are also used throughout the course of therapy, and have become a hallmark of this model. Other solution-focused techniques include the formula first session task, which has the therapist asking the client at the first session to observe what is going on in their lives that they would like to have continue (Nichols and Schwartz, 2001). Coping questions ask the clients how they are able to continue despite the presence of a seemingly hopeless problem. Taking a break midway through the session allows the therapist to collect his/her thoughts and consult with the team, to decide what parts of the session to highlight to the client (Weiner-Davis and O'Hanlon, 1989; deShazer and Berg, 1997). The techniques associated with SFBT are seen as being applicable to all clients, even though the interventions themselves are not directly related to the presenting problem. deShazer describes these techniques as "skeleton keys" which can be used to open solutions to the variety of problems that clients present in therapy (deShazer, 1985; Nichols and Schwartz, 2001).

Use of SFBT with different populations

A number of articles have been written which indicate how SFBT can be used with a variety of different presenting problems and populations. Corcoran (2000) described using a solution-focused approach as being useful with working with ethnic minority clients. She indicated that SFBT "conveys respect for cultural differences through its dominant values of client self-determination and the belief that people possess the strengths and resources to resolve their own problems" (p. 5). The author points to the aspects of SFBT, such as therapist and client working as collaborators toward a mutual goal, and its focus on behaviors and perceptions rather than feelings as being

particularly useful in work with minority clients. The author further states that these aspects afford the client respect for their particular lifestyle and are sensitive to the client's culture.

Clark (1996) advocated the use of SFBT when working with juvenile offenders and their families. He cites the difference, especially when working with this population, between blame, which focuses on past failures, and responsibility, which can highlight past successes, without ignoring accountability for past mistakes. He states, "We simply do not have to drag our juveniles and their families 'through the mud' of their own failures and defects to bring about change" (p. 64). He cites advantages to using SFBT with juvenile offenders, including aiding the juvenile justice worker in being culturally sensitive and helping to brighten the workplace atmosphere among juvenile justice workers by instilling encouragement, hope and optimism. He also indicated that this approach may be integrated and used in conjunction with practices already in place in the juvenile justice system.

Dolan (1994) discussed the benefits of using a solution-focused approach when working with clients who have experienced severe abuse. Dolan discussed how severe abuse victims could develop "rigid associational compartmentalization" as a response to the abuse (p. 276). This compartmentalization can render the abuse victim unable to access necessary internal resources. She states that using a solution-focused approach can be beneficial to these clients in that it can help them envision a brighter future and empower them to unlock and use their internal resources to overcome the rigid compartmentalization.

Osbourn (1997) discussed the use of SFBT when working with clients suffering from alcoholism. Osbourn discussed the mismatch between using SFBT with an understanding that alcoholism is a disease or is a result of biological and genetic factors. The treatment goal when using this understanding of alcoholism is abstinence. This is a mismatch because SFBT is an approach, which advocates client centered goals and a "non-pathological orientation" (p. 21). Having a psychosocial understanding of alcoholism, that is alcoholism as a learned behavior and a result of biological factors along with environmental factors, may be more compatible with using a solution-focused approach. Members of the National Association of Alcoholism and Drug Abuse

Counselors were surveyed regarding their beliefs on this subject. The results indicated that having a psychosocial view of alcoholism was more compatible with the use of SFBT with this population, while having a disease model view of alcoholism was not as reliable a predictor of endorsement of SFBT. Osbourn went on to say that following a disease model view of alcoholism does not hinder one from using SFBT with alcoholics.

In Family Based Services, Berg (1992) provided a guide for using SFBT when working with child welfare services. Guided by that work, Corcoran (1999) discussed the benefits of using SFBT when working with clients associated with Child Protective Services (CPS). She discussed the commonalities between SFBT and social work, that is the use of a strength based perspective and the belief of a systemic view of change. She further identified the difficulty of putting these beliefs into concrete practice when working with individuals who are abusing their children. Corcoran offered the idea that using SFBT with the court-mandated clients that are often involved with CPS can help foster a good client/therapist relationship, in that SFBT is an approach which is collaborative and accepting of the client's view of their situation. Further, use of a collaborative and strength-based approach like SFBT, rather than a directive or confrontational approach, can help CPS workers feel less overwhelmed, as SFBT puts more of the responsibility to change on the client.

Kok and Leskela (1996) discussed the benefits of integrating a medical model of family therapy with a solution-focused approach for use with clients hospitalized for psychiatric reasons. Although use of a medical model involves the assignment of a DSM diagnosis to clients, integrating this with a solution-focused approach can direct the treatment staff to shift their attention to potential solutions and client's strengths rather than keep a negative focus on client's deficits. The authors support the benefit of integrating the medical model with a brief therapy approach, given the occurrence of brief hospital stays by clients because of insurance or financial reasons. The authors offered concrete ways in which a solution-focused philosophy can be used with inpatient psychiatric clients, including reframing the hospitalization as a transition from failure to success and including coping and exception questions to the assessment process. The authors indicated the benefits of using this approach, which included creating a more

optimistic atmosphere among the treatment staff and clients and harboring a more respectful relationship with clients and their families.

Rhodes and Jakes (2002) discussed the use of a solution-focused approach with clients experiencing a psychotic crisis in the form of a case study of an individual suffering from paranoid schizophrenia. The authors pointed out that since this approach to therapy emphasizes the client's reality and language, SFBT could be more useful, as compared to cognitive behavioral therapy, when working with psychotic clients. Instead of trying to convince clients that delusions are not real, the solution-focused therapist would honor the client's reality and follow the direction of the client. The authors further note that SFBT may not be suitable for all types of delusions, indicating this particular client was terrified of and wanted to stop the situation depicted in his delusions, his fear was external, and he was able to form a therapeutic relationship.

Hoyt and Berg (1998) discussed the use of SFBT when working with couples in therapy. The authors discussed the basic principle that a solution-focused therapist works to help clients perceive their situations differently, so that they can behave in those situations differently. As Hoyt wrote, "How we look influences what we see, and what we see influences what we do and around and around the process goes, recursively" (p. 204). SFBT can be useful in couples therapy, when discussing the couple's expectations of each other, in highlighting what has worked in the couple's interactions, and in helping the couple avoid escalating past complaints, which can often lead to an unproductive cycle of blaming each other and defending oneself.

Neilson-Clayton and Brownlee (2002) discussed the use of SFBT with cancer patients and their families, although modifications to the approach, specifically the miracle question, are needed when working with this particular population. The authors contend that SFBT is particularly well-suited for use with cancer patients and their families because "the nature of the disease is such that crises are intermittent throughout the course of the illness" (p. 4). Given that intermittent crisis is part of living with a diagnosis of cancer, the therapist can capitalize on the times when the patient and patient's family were able to successfully cope with the illness and live through a period of crisis. The authors also discuss the problems related to using the miracle question with this population, as the connotation of the word "miracle" is almost always associated with

the elimination of the cancer itself. The authors devised an alternative wording to the miracle question, which appeared to be well-received by their patients. The alternative question asked the patients to "suppose [they] took time to consider [their] situation and decided that the concerns that brought [them] into counseling were no longer present." (p. 7). The authors further discuss the mismatch between using an approach that places emphasis on positive emotions and the reluctance a patient/family member may feel given the gravity of a diagnosis of cancer. They indicate that the use of coping questions during the times a patient/family member may be feeling overwhelmed by negative emotions could be helpful.

Dzelme and Jones (2001) discussed the benefits of using a solution-focused approach with male cross dressers and their partners. The authors describe male cross dressers as an often misunderstood population, and that research shows that efforts to eliminate the cross-dressing behavior are often unsuccessful. Using a solution-focused approach is a way to treat this population in a way that does not pathologize this behavior, and therefore help the cross-dresser and his partner to understand the behavior and discuss it in a way that is comfortable for both of them. In that way, they are better able to develop their own solutions to living with this type of behavior. The authors also discuss the benefits of having clear, workable goals when using a solution-focused approach, which can be helpful to these clients in particular. They contrasted this by citing research that described more traditional treatment of cross-dressers by other mental health professionals who provided treatment without clearly stated goals, which left clients feeling unsatisfied with treatment (Bullough and Bullough, 1993).

In summary, as illustrated by the above authors, SFBT is an approach that can be used with a variety of different populations presenting with different problems. Use of SFBT affords the therapist the opportunity to work with the client in a respectful and hopeful manner, by focusing on resources and strengths and using a collaborative, rather than a directive, approach. There is also mention that using SFBT can be beneficial to the therapist by helping the therapist feel less overwhelmed and creating a brighter, more positive atmosphere in the workplace (Clark, 1996; Corcoran, 1999; Kok and Leskela, 1996).

Effectiveness research

In 1997, deShazer and Berg wrote an introduction to a special issue of the Journal of Family Therapy, which dealt specifically with research aspects of SFBT. While there had been informal research projects done on this approach at the Brief Family Therapy Center, the authors noted that, at that point, standardized research regarding this approach had been limited. They identified four characteristics that could serve as indications that SFBT was taking place in the therapy room. Those characteristics were the therapist asking the miracle question during the first interview, the therapist asking the client a scaling question at least once during the first interview, the therapist taking a consulting break and the therapist returning from the consulting break with compliments for the client and a homework task. The authors noted that, for research purposes, if any or all of these characteristics were missing from a therapy session, then the therapist was not practicing SFBT. However, the authors did make the distinction that, clinically speaking, the therapist could still be using SFBT even if these characteristics were missing.

McKeel (1996) provided a clinician's guide to research on SFBT in the Handbook of Solution Focused Brief Therapy. In it, he discussed two different kinds of studies, outcome and process studies, and reviewed the research that had been conducted on SFBT up to that point. McKeel discussed three outcome studies, which indicated that a majority of clients receiving SFBT were able to accomplish their treatment goals (Kiser, 1988; Kiser and Nunnally, 1990). While limitations regarding these studies were also noted, such as small sample sizes and lack of control group, McKeel indicated that more well-designed research studies could help further the credibility of SFBT.

Gingerich and Eisengart (2000) conducted a review of the outcome research on Solution Focused Brief Therapy. They reviewed fifteen studies, each of which were rated as being a well-controlled, moderately controlled or poorly controlled study. The authors concluded these studies provide preliminary evidence toward the effectiveness of SFBT. The following three studies, were included in this review and are detailed in this literature review. The Lindforss and Magnusson study was described by Gingerich and Eisengart as being a well-controlled study. The Zimmerman, Prest and Wetzel study was described as being moderately controlled and the Eakes, et al study was described as being a poorly controlled study.

Lindforss and Magnusson (1997) wrote about a study conducted at the Stockholm Regional Prison and Probation Administration at Hageby Prison, which began on January 1, 1993. Sixty prisoners participated in this study, with half of them being assigned to the treatment group receiving SFBT. The individuals in the treatment group met with a therapist for an average of five sessions. The study looked at recidivism rates after release from prison, with two measurements of the dependent variable taken after twelve months and again after sixteen months. After twelve months, 53% of the treatment group had committed a new offense following release from prison, compared to 76% of the control group committing a new offense. A Z test was used to test statistical significance, which indicated the difference between these two groups was statistically significant ($p=.033$). After sixteen months, 86% of the control group had recidivated, with only 60% of the treatment group incurring new offenses. The difference between the two groups was also significant ($p=.0188$).

Zimmerman, Prest and Wetzel (1997) conducted an empirical study of the use of SFBT in a group setting with couples. Twenty-three couples participated in a six-week Solution Focused Couples Therapy group. They were recruited by responding to newspaper advertisements offering couples therapy. Thirteen couples participated in a comparison group. They were recruited through flyers requesting voluntary participation in a research study. The thirteen couples in the comparison group completed the pre and post-test measures, however did not receive treatment. Both groups completed the Marital Status Inventory prior to treatment, which indicated no significant differences between the two groups. Both groups also completed the Dyadic Adjustment Scale (DAS) prior to and after the completion of treatment. The DAS scores for the couples in the treatment group showed statistically significant improvement. The authors also noted that the post-test DAS scores of the treatment group approached the pre-test scores of the comparison group. During treatment, the treatment group couples also reported positive changes in their relationship, such as a decreased intensity in their arguments, more frequent physical affection and more effective problem solving.

Eakes, et al (1997) conducted a pilot study using SFBT with schizophrenic clients and their families. Ten clients, diagnosed with schizophrenia, who were receiving services from a community mental health center, and their families were recruited for this

study. The study compared the pre-test and post-test scores on the Family Environment Scale (FES) of the families in an experimental and control group, with the experimental group receiving five sessions of SFBT, and the control group receiving five sessions of traditional follow-up therapy. The mean pre-test scores and mean post-test scores for the experimental and control groups were analyzed using ANOVA procedures. Statistically significant differences were found for the expressiveness, active-recreational and incongruence scales of the FES. The authors indicated that their data showed that the families receiving SFBT showed increased scores on the scales measuring expressiveness and active-recreational orientation. The experimental group also showed decreased scores on the incongruence scale, which indicated that the families receiving SFBT increased their agreement on issues surrounding social climate.

There have been other studies examining the effectiveness of SFBT, which were not included in Gingerich and Eisengart's review. Lee (1997) discussed the findings of a study conducted that examined the effectiveness of solution focused brief therapy when working with children and their families. Families receiving treatment at this agency from 1990 to 1993 were included in this study, with responses from 59 families available at the time of data analysis. Families were contacted six months after terminating treatment, and were given a 14-item questionnaire, which covered goal attainment, current status of the presenting problem, development of new problems and positive changes, and perceptions of the therapeutic experience. The results indicated 64.9% of the sample reported their therapeutic goals as being met or partly met within an average of 5.5 sessions. Lee indicated these results provide initial evidence regarding the effectiveness of this approach when working with children and their families.

Ingersoll-Dayton, Schroepfer and Pryce (1999) conducted a study testing the efficacy of SFBT when working with the family members of nursing home residents with dementia. Data was collected from twenty-one family members and 63 certified nursing assistants (CENA) associated with nursing home patients. To be included in the study, the nursing home patient had to be 60 years old or over, have a diagnosis of irreversible dementia, currently visited by a family member at least every two weeks and display either physically aggressive, verbally aggressive or wandering behavior. Between June 1997 and August 1998, four social work graduate students worked with the family

members and CENAs using a solution focused approach, which included questioning them about positive qualities and exceptions to the problem behaviors and offering suggested approaches for managing the problem behaviors. A modified version of the Caretaker Obstreperous-Behavior Rating Assessment (COBRA) scale was used to measure changes in the problem behaviors. Analysis of variance was used to test the results and showed that aggression and wandering decreased in severity and frequency and patients showed more mastery over these problem behaviors ($p<.05$).

In summary, there have been several studies conducted which provide some evidence of the effectiveness of SFBT. The studies reviewed here again reflect that SFBT has been used with a variety of different populations. There has also been some criticism regarding the poor design of some of these studies.

In addition to reviewing outcome studies on SFBT, McKeel (1996) also reviewed process studies, which provide research on effectiveness of particular SFBT techniques. He noted that these studies may be more beneficial and informative to clinicians trying to use this approach. McKeel reviewed studies that examined pretreatment change, presuppositional questioning, the First Session Formula Task, client-therapist collaboration and the use of solution-focused language. The author concluded that these interventions were generally found to be effective and noted that more research demonstrating the effectiveness of the different SFBT techniques may be helpful for clinicians.

McKeel (1996) also discussed a study conducted by Skidmore in 1993. In that study, Skidmore surveyed graduate students from SFBT training programs about their use of certain SFBT interventions and which they found most therapeutic: exception questions, the miracle question, scaling questions and pretreatment change questions. The results of this study indicated that the students rated the miracle question as being most therapeutic. Scaling questions were rated as being used most frequently and the best way to evaluate progress. Pretreatment change questions were rated as the least used and most difficult to use during session (Skidmore, 1993).

Metcalf et al (1996) conducted a qualitative analysis of client and therapist perceptions to address the differences in clients' and therapists' perceptions of the therapeutic process and the differences between the assumptions underlying SFBT and

what therapists actually delivered during the therapy sessions. Six co-habitating couples, who had successfully terminated treatment at the Brief Family Therapy Center, and their therapists were interviewed regarding their experience receiving therapy from this agency. A purposive sample was chosen for this study, as the researchers wanted to obtain information about favorable therapeutic outcomes. The data were organized into three main themes, which evolved during the data analysis. These were the therapist's role and what happens during SFBT, the reasons clients sought therapy and terminated therapy, and how change occurs. Overall, the results indicated support for SFBT, with clients perceiving the therapy they received as helpful. The authors noted the results also indicated the therapists taking more of a directive role with these clients, with clients describing a less collaborative termination process than what the model dictates. The authors also suggested that an emphasis on client-therapist relationship rather than use of solution-focused techniques, may better account for the effectiveness of SFBT.

Adams, Piercy and Jurich (1991) conducted a study on the effects of the Formula First Session Task (FFST) on compliance and outcome in family therapy. Sixty couples/families, who were receiving therapy from two different clinical sites, were selected to participate in this study. The families were divided between three treatment conditions: FFST followed by problem-focused therapy, FFST followed by solution-focused therapy and problem-focused intervention followed by problem-focused treatment. The problem-focused intervention was identical to the FFST, with the exception of asking the client to pay attention and report the following session on the problems that are occurring in their life. The results of this study indicated that therapists judged families who had received the FFST as being more compliant that those who had received the problem focused intervention. Furthermore, therapists reported an improvement in the presenting problem and a clearer picture of the client's goals for those families who had received the FFST. Families who had received the FFST also reported a clearer understanding of their therapeutic goals as well as an improvement in their presenting problem. The authors noted that this study was not intended to test the SFBT model as a whole, but rather an intervention associated with this model.

In summary, a review of studies examining the process of SFBT indicates that many of the interventions associated with this model are considered effective by both

therapists and clients. Metcalf et al pointed out that this model's effectiveness may be better accounted for by the relationship created between the client and therapist when this model is used, rather than the use of SFBT techniques and interventions.

Gaps in SFBT research – future areas of study

There have been a number of studies conducted which indicate SFBT has been used with various populations and which provide some evidence regarding the effectiveness of this model, as shown through both outcome and process studies. Future areas of research regarding SFBT seem to be additional studies considering the client's perception of therapy and studies having more of a controlled research design. Studies addressing and exploring SFBT training and supervision issues could also be beneficial in adding to the body of research on SFBT.

Overview of MFT training and supervision

The present study examines how trainees currently experience SFBT training and supervision. In order to provide some background information, an overview of family therapy training and supervision will be provided.

In 1988, Liddle, Breunlin and Schwartz described family therapy training and supervision as one of the field's "most active and rapidly expanding subsystems" (p. 3). They identified training and supervision as important to the continuing development of the family therapy field. They further pointed out that training and supervision are the processes by which the field's knowledge, values, skills and roles are passed on to new clinicians, and the primary way the field can evolve.

Todd and Storm (1997) discuss the distinctions between training and supervision. They define training as the "comprehensive teaching of theories, skills, and techniques that either precedes or occurs alongside the development of clinical skills" (p. 1). Training involves the didactic part of the learning process, in which skills and theoretical frameworks are taught by means of lectures, readings, skill training exercises and clinical work. The authors describe the relationship between trainer and student as hierarchal, with the trainer taking on an expert role. They further indicate the relationship between trainer and student is usually limited in regards to time, and there is little legal liability on the part of the trainer.

Todd and Storm (1997) define supervision, on the other hand, as an ongoing relationship focused on the development of the therapists' clinical skills in a practice setting. The authors go on to state that certain elements of supervision should be included, such as an experienced therapist monitoring a less experienced therapist, who is seeing real clients in a real clinical setting. The experienced therapist works to safeguard the welfare of the client and works to enhance the less experienced therapist's skills. Unlike the relationship between trainer and student, the liability in the supervisor/supervisee relationship is higher. The authors further indicate that the supervisor takes on the added responsibility of monitoring the "professional development of the supervisee and their socialization into the profession" (p. 3).

Family therapy training and supervision differs from training and supervision in other disciplines, such as psychology and psychiatry (Liddle, Breunlin and Schwartz, 1988). Given the systemic nature of family therapy, training and supervision in this field will involve a requirement that trainees show their clinical work to colleagues, an openness to hear comments about one's clinical work and a recognition that an individual must be seen as being a part of every interaction they have (Todd and Storm, 1997). As such, both supervisors/trainers and their supervisees/trainees contribute to the process of supervision and training.

Anderson, Rigazio-Digiolio and Kunkler (1995) discussed the issues and directions in family therapy training and supervision. Regarding the modalities in training and supervision, the authors describe a continuum of modalities, ranging from the supervisor directly engaging with the supervisee and client to modalities in which the supervisor does not directly engage in the therapeutic process. The continuum also ranges from the supervisor working with raw data of the supervisee's work to the supervisor working with the supervisee's report of his/her work. The modalities that involve the supervisor directly engaging in the therapeutic process include live supervision, co-therapy, and direct case consultations with the client. Audio and videotape supervision represent the middle of this continuum, in that raw data about the therapeutic work of the supervisee is still provided to the supervisor, although the benefit of the supervisor's immediate intervention is not available. At the opposite end of the continuum, include modalities such as case consultations. In this modality, the

supervisor does not have the benefit of the raw data of the clinical work being done, and works with the supervisee's report and interpretation of his/her clinical work.

The concept of isomorphism was another important theme that developed in the literature on family therapy training and supervision. Isomorphism refers to the idea that the patterns and content of a family therapy model are replicated in the training and supervision of that model (Liddle, Breunlin, Schwartz and Constantine, 1984). As such, each model of family therapy will have different approaches to training with those training approaches reflecting the theoretical framework of that particular model of family therapy as well as the theoretical framework of the trainer/supervisor. For SFBT, training and supervision in this model may translate into a more non-hierarchical and collaborative relationship between trainer and trainee. The development of school-specific models of family therapy training may not contribute to a consensus of what may be empirically effective, since each approach offers ideas about how best to train and supervise therapists in that specific model. These authors do note that school-specific models of training and supervision have informed the field in that they provide information about a variety of training methods and approaches and seem to further clarify the core beliefs and assumptions inherent in each model.

Anderson, Rigazio-Digilio and Kunkler (1995) recognized the development of constructivist philosophies and the therapeutic models associated with these, such as SFBT. The constructivist therapeutic models of the post-modern era introduce more collaborative relationships and "create an atmosphere of dialogue aimed at developing, guiding and sharing meaning systems" (p. 495). The training and supervision of these models would entail a more active role on the part of the trainee. The authors further note that theories regarding the training and supervision in these models should be developed and investigated to guard against both supervisors and supervisees using just any construction of reality.

In summary, training and supervision in the MFT field is considered to be distinct from training and supervision in other disciplines, such as psychiatry or psychology. In the family therapy field, both the trainer/supervisor and trainee/supervisee are seen as contributors to the teaching and learning process. Within the family therapy field exists different approaches to therapy. Considering the concept of isomorphism, the training

and supervision in each of these models may also be distinct. A discussion of SFBT training and supervision is included in the following section.

Discussion of SFBT training and supervision

Wetchler (1990) discussed the benefits of using a model of solution-focused supervision. Wetchler indicated that beginning therapists may find the task of learning systemic ideas and translating those into clinical practice confusing and overwhelming. He also discussed the idea that individuals develop a cognitive schema, which filters the way one views the world and subsequently guides one's behaviors and actions. Other supervision models that focus on the problems the supervisee is experiencing may contribute to the supervisee's feelings of inadequacy as a therapist, which in turn would negatively affect his/her clinical self-esteem. Wetchler's model of solution-focused supervision has the supervisor focusing on strengths and exceptions and positive parts of the supervisee's clinical work. By being able to recognize his/her successes, the supervisee is able to develop a clinical schema, based on those successes. This would in turn help build the supervisee's self-esteem regarding his/her clinical work. Wetchler further makes the connection that a client would be more likely to follow the suggestions of a confident therapist, rather than one who is uncertain and unsure of his/her abilities. Wetchler identifies two distinct parts of a solution-focused supervision session, a focus on the supervisee's strengths followed by a focus on clinical education. Finally, Wetchler indicated that, although constructivist in nature, this model of supervision could be used with other theoretical orientations, other than SFBT.

Marek, et al (1994) discussed a model of solution-focused supervision, which simultaneously integrates a focus on solutions with a focus on clinical education. The authors, like Wetchler, indicated this model of supervision could be used with many different theoretical orientations, but noted that the use of this model of supervision can be especially beneficial when the supervisee seeks to learn/practice SFBT. The authors note that the supervisor and supervisee can take advantage of their shared knowledge of SFBT, and the use of this model of supervision enables the supervisee to have SFBT "modeled" for them. Additionally, since the supervisor is using many of the same techniques used in SFBT with the supervisee, the supervisee can become more sensitive

to how a client may perceive these techniques, and adjust language and use of these techniques accordingly.

Following the concept of isomorphism, the primary goal in SFBT training and supervision mirrors the primary goal when practicing SFBT with clients. The supervisor works to amplify and point out exceptions to the problems in the supervisee's work, rather than focus on the actual problems. There are two assumptions underlying SFBT supervision. The first is the idea that supervisees will cooperate with their supervisors. With this assumption, it becomes the task of the supervisor to identify how the supervisee is cooperating with them. The supervisee could follow the supervisor's suggestions, modify the suggestions somewhat, or not follow the suggestions, all of which is viewed by the supervisor as a cooperative response. The second of the assumptions is that supervisors help change take place by using presuppositional language and questioning when working with supervisees. Following the concept that change is constant in SFBT, the supervisor use of words such as *when* and *will*, and attention paid to their supervisee's talk about change, will result in a positive impact on the supervisees' work with clients. The typical modalities used in solution-focused supervision are the use of live supervision and videotape supervision. With live supervision, the use of the consulting break, one of the hallmarks of SFBT, is helpful not only for the client, but for the supervisee to receive additional encouragement regarding his/her work (Selekman and Todd, 1995, Todd, 1997).

Todd (1997) describes four different solution-focused supervisory interventions. The use of compliments can be integrated with various aspects of supervision, from weaving compliments about the supervisee in a telephone call-in during live supervision to pointing out a supervisee's strengths throughout a videotape supervision session. Scaling questions help the supervisor and supervisee gain a clear understanding of goals to be achieved. They also serve as a concrete way to measure progress toward those goals. Use of the miracle question in relation to supervision can be beneficial by helping supervisees produce new perspectives and behaviors when faced with the dilemma of a stuck case. Finally, the author notes that supervisors should be aware of what supervisory practices have worked and which practices have not worked with the supervisee, in order to learn what works and what to do differently.

Selekman and Todd (1995) expand on these supervisory interventions, to include the use of future-oriented questioning. Selekman also discuss the limitations to using a solution-focused model of supervision, including handling situations in which supervisees present with the "wrong goals" (p. 28) and handling lack of clinical knowledge. The authors indicate it would be inappropriate for supervisors to ignore when the supervisee's goals do not consider safety or ethical issues. In addressing lack of clinical knowledge, the authors suggest supervisors pay attention to their supervisees' needs in this area, and caution against assuming the supervisees does not have the knowledge or ability to find the needed answers on their own.

Triantafillou (1997) described an exploratory study of the use of solution-focused supervision practices in a residential children's mental health agency in Ontario, Canada. The purpose of this study was to determine whether or not the use of solution-focused training and supervision could positively impact practice and client outcomes. The participants in this study included 14 of the agency's supervisory staff and 10 of he agency's direct care workers. The solution-focused training program consisted of four three-hour classes, held on a weekly basis. The classes introduced the solution-focused model, and the use of SFBT techniques with suicide prevention, anxiety disorders, motivational issues, anger management, crisis intervention and supervision. Reading materials on supervision included the articles written by Wetchler (1990) and Marek et al (1994). The data from this study were obtained from the participants' responses to the Client Satisfaction Survey (Larsen, Attkinsson, Hargreaves, and Nguyen, 1979) as well as the agency's records on the occurrences of serious incidents and dispensing of psychotropic medications to the clients. The results of this study indicated that the use of solution-focused supervision had a positive impact on the clients served by the agency. Both the average number of serious incidents and the use of psychotropic medications to control aggressive behavior were reduced. Responses from the supervisory staff and direct care workers indicate support of this model of supervision. Staff indicated the model of supervision was applicable to their work and helped to empower both staff and clients to prevail over the difficulties associated with residential settings.

In summary, solution-focused supervision, with its emphasis on strengths rather than weaknesses, may be helpful in developing good clinical self-esteem in beginning

therapists, while still allowing the supervisor the opportunity to provide needed clinical information and guidance. This model of supervision may also be especially helpful for those therapists who seek to practice SFBT, in that the supervision serves as a way for the approach to be "modeled" for them. In a study examining solution-focused supervision, both supervisors and supervisees indicated support for this model of supervision.

Discussion of research concerning MFT training and supervision

The following section will discuss some of the research studies that have been done concerning MFT training and supervision. In 1979, Kniskern and Gurman presented the first review of the research done in the area of family therapy training. At that time, research in this area was minimal. Since then, much of the existing research has focused on what skills should be taught to trainees and how those skills should be taught (Maynard, 1996). Figley and Nelson, for example, (1989) identified characteristics and skills that beginning family therapists should have. Additionally, other areas that prior research seemed to focus on are the effectiveness of training, the development of instruments to assess clinical development and the impact of training on skill development and clinical outcomes (Bischoff, 1997).

Hawley, Bailey and Pennick (2000) conducted a content analysis of the research that had been done in family therapy journals. Included in this analysis were all empirical articles in the 1994 to 1998 issues of the *American Journal of Family Therapy*, *Family Process and* the *Journal of Marital and Family Therapy*. The authors concluded that the largest category of studies done concerned family process and individual issues, without a clinical context. The authors also noted that there were relatively few articles concerning training and supervision issues in family therapy. The authors went on to say that, since training and supervision is a distinguishing aspect of family therapy, more research in this area would be important.

Street (1997) reviewed eight studies concerning research in the field of family therapy training, which focused on three major themes - trainees' experiences outside of the training environment, trainees' perceptions of their experiences and methods of training research. Included in this review was a summary of earlier key findings from past reviews of research concerning family therapy training. One conclusion he made in this review was that the majority of the studies in this area were quantitative. He

described family therapy training as a developmental process during which a trainee interacts with several different elements in their training environment, which contribute to the learning experience. Those elements may include the trainer, the teaching methods used, the other trainees and the experiences that each brings to that environment. Using qualitative measures to study that process may provide a fuller and more accurate description that could be beneficial to trainees.

One of the studies that Street reviewed illustrated the benefit of qualitative analysis in addition to quantitative analysis in these studies. Zaken-Greenberg and Neimeyer (1986) conducted a study of family therapy trainees. The participants in this study were students in a counseling psychology course. The experimental group consisted of those students who participated in a class with a module on structural family therapy. The control group attended the course without the module on structural family therapy. The study sought to gather information on the difference in skill development between these two groups, with participants being asked to complete a Family Repertory Grid (FRG) and respond to therapeutic scenarios, which were presented on videotape. The experimental group in this study generated a greater number of therapeutic alternatives than the control group, and both groups of students showed a decrease in the number of bad interventions used. The findings also indicated that, for the family therapy trainees, conceptual organization scores on the FRG only increased for those trainees who had minimal prior exposure to family therapy concepts. The authors argued that this is evidence that a trainee's prior experience may have an impact on training. Street noted that these authors did not offer a hypothesis regarding this relationship. He further indicated that a qualitative analysis of these trainees' experiences might have been beneficial in offering insight into this relationship.

In his review of these eight studies, Street also discussed the importance of considering multiple perspectives, that of the trainer as well as the trainee, when conducting family therapy training research, indicating that this type of approach "may lead to the development of appropriate theory and practice grounded within the context of adult learning and professional education" (Street, p. 92).

In summary, research in the area of family therapy training and supervision has been relatively sparse, especially when compared to other categories of studies in the

family therapy field. Other authors have contended that family therapy training is a distinguishing aspect of the field and that the process of training involves several factors, which contribute to the learning process. More research in this area, which examines these issues, is warranted.

Summary of literature on supervisor and supervisee perspective on training issues

There have been some studies, which examine both the supervisor and supervisee perspective on training issues. Henry, Sprenkle and Sheehan (1986) conducted a survey of both faculty and students from several AAMFT accredited and non-accredited training programs. In these surveys, the majority of the respondents were students, which would reflect the importance of gaining the student's perspective when studying family therapy training programs. The data from the survey were analyzed using quantitative measures and focused primarily on comparing and contrasting the environment in a university setting versus a training institute setting. The findings indicated that, overall, there were more similarities than differences between the different types of training contexts, with both settings endorsing more participation in cooperative activities with each other, such as faculty exchanges and joint research projects. While this study was helpful in bringing to light some of the issues in family therapy training, it did not provide much of a description of the respondents' experiences.

Wetchler, Piercy and Sprenkle (1989) conducted a study on supervisors' and supervisees' perceptions of supervisory techniques. A randomly selected group of AAMFT Approved Supervisors and their supervisees participated in this study. Three hundred eighteen supervisors and 299 supervisees were asked to respond regarding the effectiveness of 17 different supervisory techniques. They were also asked to rank the three most used/received techniques. Both supervisors and supervisees rated videotape supervision as the most effective supervisory technique and individual case consultation as the most used supervisory technique. The participants were also questioned regarding their theoretical orientation. The authors pointed out that theoretical orientation appeared to be related to ratings of effectiveness and use of supervisory techniques, with structural/strategic supervisors favoring live supervisory techniques. The authors indicated these results were consistent with the literature in family therapy supervision on isomorphism.

Wetchler and Vaughn (1992) examined the perceptions of both supervisors and supervisees regarding what they considered to be effective techniques used in supervision. Participants in this survey were asked to describe a "critical incident that had a positive effect on the supervisee's clinical development" (p. 129). The data in this study were analyzed using quantitative methods, ranking the techniques in order of how many supervisors and supervisees identified the technique as being used in a critical incident. For both supervisors and supervisees, the two most often identified techniques associated with the critical incident were individual case consultation and live supervision. Additionally, the most often identified type of live supervision was that which included a mid-session consultation break.

Wark (1995) conducted a qualitative study on the perceptions of supervisors and supervisees on live supervision events. Wark discussed the benefits of using qualitative methods to study supervision experiences, pointing out that each individual's sense of reality guides that person's behavior in therapy and supervision and that such analysis can provide valuable information to supervisors. Five pairs of supervisors/supervisees from an AAMFT accredited doctoral training program were observed by the researcher from behind a one-way mirror and then interviewed. Wark identified the themes of teaching/directing, supporting and collaboration as important to supervisee development.

Reichelt and Skjerve (2000) conducted a qualitative analysis on the supervision of inexperienced therapists. The primary research questions for this study were what do supervisors emphasize in working with supervisees and how do supervisees react to various supervisory characteristics. Eighteen supervisor/supervisee pairs were interviewed separately as they listened to sequences from one of their taped supervisory sessions. Supervisors were questioned about what had happened in the sequence, the reason for the intervention, the goal of the intervention and how they believed the intervention affected the supervisee. The supervisee was questioned about what happened in the sequence, why they believed the supervisor intervened and how the intervention affected them. Expanding therapeutic repertoire and emphasizing theoretical understanding were themes that developed when examining supervisor's intentions. Positive feedback and co-construction of alternative strategies were themes that developed when examining supervisor's strategies. An analysis of the supervisee's

responses generated themes of appreciation for a supportive, yet challenging, supervisor as well as appreciation for assistance in case conceptualizations.

In summary, research, which considers both the supervisor's and supervisee's perspective, have provided some insight on training issues, such as the relationship between supervisor theoretical orientation and supervisory practices, and the appreciation by supervisees of a collaborative, supportive, yet challenging supervisory relationship. These studies help to inform the family therapy training, however, an exploration into the developmental process of training, examining how the different aspects of the training environment contribute to the learning process, may help to further inform the field.

Summary of literature on trainee/supervisee perspective on training issues

Recognizing the need to focus on the perspective of the trainee in family therapy training research, Hines (1996) surveyed 205 graduates from accredited, degree-granting marriage and family therapy programs. These individuals graduated from their respective programs in 1980, 1983 and 1986. The graduates were asked to respond regarding their current employment, the extent and nature of the training they received, the extent to which the program prepared them to work as marriage and family therapists and their recommendations for increased or decreased emphasis on specific aspects of training. Approximately 27% of the masters level graduates reported working in non-profit outpatient settings and 49.1% of the doctoral graduates reported working in college or university settings. The masters level graduates reported 54.5% of their clinical work involved systems oriented thinking and 62% of the doctoral graduates reported 62% of their clinical work involved systems thinking. Both the masters level and doctoral graduates reported they believed their training program prepared them to work as marriage and family therapists. The participants further recommended more emphasis on alcoholism, other substance abuse, sexual abuse and domestic violence issues.

Anderson, Schlossberg and Rigazio-Digilio (2000) conducted a survey concerning family therapy trainees' evaluations of their best and worst supervision experiences. The primary focus of the study was to explore the factors that discriminate between these two types of experiences and the data collected in this study was analyzed using quantitative methods. The findings of this study suggest that trainees were generally satisfied with the quality of training they were receiving in COAMFTE

accredited programs. Best supervision experiences occurred in open, respectful and supportive environments where an emphasis on personal growth was balanced with the development of technical skills. While this study provided some insight into the trainees' perceptions of their supervision experiences, a study employing qualitative methods may provide a richer description of a trainee's experience.

Weiling, et al., (2001) conducted a study of doctoral students' perceptions of the influence of postmodernism in the field of Marriage and Family Therapy, specifically in the areas of theory, research and clinical practice. The data for this study was gathered from focus group discussions and were analyzed using qualitative measures. It was noted that several of the participants in this study voiced an appreciation for the opportunity to share their own views on postmodernism as well as learn from listening to the views of others. Enthusiasm and a desire for continued discussion was also expressed among these students. While this study is not directly related to family therapy training, it does provide some evidence that students would welcome the opportunity to share their perceptions as well as learn from the hearing the perceptions of others.

Deacon and Piercy (2000) discussed the benefits of using qualitative measures to evaluate family therapy programs. The authors stated "there are plenty of expert opinions regarding what good family therapy education should be. However we need to hear more from one group of neglected 'experts' – family therapy trainees...We believe it is important for students to have a voice in their training. They have a unique perspective on the training they receive" (p. 40). They discuss the benefits of using a participatory approach, to gather feedback to be used to improve programs, as well as empower students to be part of the evaluation process.

Gaps in family therapy training/supervision research – future areas of study

In their review of the issues in family therapy training and supervision, Anderson, Rigazio-Digilio and Kunkler (1995) state "despite a proliferation of studies, we still lack a coherent base of research findings from which to inform the training and supervision field" (p. 494). These authors point out that issues such as the influence of training on clinical outcomes, the relationship between hours of experience and clinical competence, and effectiveness of various training and supervisory modalities should be addressed. They further indicate research on the process by which training and supervision occur

should be explored. Qualitative studies, especially those considering the perspectives of the supervisor, supervisee and/or client, on these issues would also help to inform the research base on family therapy training and supervision. The current study qualitatively examines how trainees currently experience SFBT training, what they found most helpful when learning this model as well as what aspects of their learning environment helped facilitate their learning process.

CHAPTER THREE: METHODS

The purpose of this study was to examine the process that trainees experience when learning how to do Solution Focused Brief Therapy (SFBT), specifically examining what training methods they found most helpful and how they integrated their pre-existing philosophies about people, their problems and the therapeutic process with the tenets of SFBT. The study also examined the distinct moments, which happen for trainees that indicate to them that this approach to therapy is working for them. The distinct moment served as a marker that the trainee had successfully learned SFBT and integrated its tenets with their own pre-existing philosophies. Given the purpose of the study, a qualitative approach was most appropriate. Data collection involved written responses from email questionnaires and verbal responses from telephone interviews and data analysis was concerned with giving a description, including common concepts and themes, but also including information that does not fit into the majority of the picture. While commenting on common concepts and themes may provide general information about the process trainees experience, including information that is not consistent with these themes adds to the richness of the description of the training process. Boss et al. wrote, "What positivists call anomalies or statisticians call outlyers, phenomenologists call reality" (p. 91). This is also more consistent with a qualitative approach (Boss et al., 1996).

Participants and Recruitment Process

In June 2002, I met with the members of the newly formed Solution Focused Brief Therapy Association, a group of approximately twenty-five SFBT trainers who are meeting to exchange ideas about the different training methods used to teach this approach. These are trainers who teach SFBT in either an academic setting, a post-graduate training facility, or in workshops. They are also trainers who learned SFBT from its founders, and are committed to teaching a purer form of this model. The purpose of meeting with the members of this group was to present my proposed study to them and to request their assistance in providing the names of two or three of each of their trainees who they feel have successfully adopted SFBT and who might be willing to participate in this study. Since the trainers were asked to provide names of successful adopters of

SFBT, this study would be able to provide information on what works when learning and practicing SFBT. The trainers were not given a specific definition of what a successful adopter of this model was, with each trainer using his/her own judgment regarding this definition.

Generalization of the findings to the larger population of trainees was not the goal of this study. Rather, the goal was to gather enough information to present an in-depth and accurate description of the participants' experiences. Since generalization is not a goal, probability sampling techniques were not necessary (Nelson, 1996). Given that, I used a convenience sample of trainees who were willing to participate. Since a phenomenological approach does not need a large number of participants to meet its goal, I considered my sample sufficient when I received fifteen email questionnaire responses and when eight participants agreed to participate in the telephone interviews (Boss et al., 1996).

Procedures

The primary method of data collection was through completion of questionnaires sent via email, with follow-up interviews conducted via telephone. The trainers participating in the Solution Focused Brief Therapy Association came from various parts of the country, and referred their trainees, who were also residing in different parts of the United Stated and Canada. Therefore, it was not possible to meet personally with my study participants. It was also not financially efficient to administer my research questions to all of the study participants by telephone or mail. Contacting the participants electronically, and allowing them to respond likewise, provided a convenient and cost-efficient way not only to distribute the research questionnaire but also for the participants to respond to such a questionnaire.

Email questionnaire

Once a list of possible participants was compiled, I contacted each of the participants via email, attaching two documents to each message, the informed consent and the questionnaire. The message to the participants introduced myself, explained that I received their name and email address from their SFBT instructor and briefly explained my study and the two attached documents. The message also indicated that their participation in this study was voluntary. One of the attached documents was the

informed consent, detailing the study and any possible risks or benefits to the participant. In lieu of signing and sending the informed consent, the participant was advised that by returning their response, they were giving the informed consent to participate. Participants were asked, if they did choose to participate in this study, to send their response within thirty days. The informed consent is included in Appendix A.

The second document (see Table 3.1) contained the research questions and questions seeking demographic information. The participant was asked to respond to the questions, and return their responses via email to me. In addition to the research questions, the participants were asked if they would be willing to participate in a follow-up telephone interview. If the participant was willing to be part of the follow-up interview, the participant was asked to include in their response to the research questions, their name, telephone number and address.

Two recruiting waves were conducted to enlist participants for this study. In June 2002, I received fifteen referrals from the members of the Solution Focused Brief Therapy Association. In August 2002, I sent emails as detailed above to the fifteen participants. For those participants who did not respond to this message, follow up emails were sent in September 2002 and again in December 2002. Having not received a sufficient number of responses from the first recruiting wave to get adequate data, I met with the Solution Focused Brief Therapy Association again in October 2002, and received sixteen more referrals. I sent emails as detailed above to these sixteen participants, with follow-up emails sent in November 2002 and December 2002, to those participants who did not respond.

Table 3.1 lists the questions that were included in the email questionnaire. The participants were asked to provide demographic data, such as age, gender and geographic location of the participant, their level of training and their years of experience as a therapist. They were also asked to provide information on how often they used certain Solution Focused techniques during their sessions. To determine the process of training, they were asked what methods were used in their training and what actions their supervisor took in teaching this model. They were also asked to provide information about their pre-existing philosophies, which either fit or did not fit with the philosophies underlying SFBT. They were also asked to describe a distinct moment in their learning

process after which they started to think that they could effectively use SFBT with their clients. The participants were advised that the questionnaire should take between 30-45 minutes to complete. After receiving responses from the participants, I contacted them via email to thank them for taking the time to participate in my study.

1. Please provide information on your age, gender, level of training and years of experience. In what setting did you learn SFBT? In what setting do you currently practice SFBT?
2. In this question, I am asking for responses based on each client you see, not necessarily each session. On a scale of 1 to 5, (1=never, 2=sometimes, 3=usually, 4=almost always, 5 = always), please rate how often you use the following with each client you see.
    - Search for pre-session change
    - Goal setting
    - Miracle question
    - Scaling question
    - Search for exceptions
    - Consulting break
    - Message including compliments and task
3. What has been most helpful in learning how to do SFBT? (reading, watching videos, examining case studies, doing role plays, using model in actual therapy sessions, observing SFBT from behind the mirror as it was being used with clients) How was this helpful?
4. What did your trainer/supervisor do that was most helpful in your learning of this model? What did you do that was most helpful in your learning of this model?
5. Describe a distinct moment or situation when something "clicked" and you felt this model was something you could use effectively with clients.
6. If someone were to come to you and ask you how to become an SFBT therapist, how would you describe that process to him/her? What learning steps would you include in your description?
7. What philosophies/theories about people or life in general did you already have that fit with those underlying SFBT?
8. What philosophies/theories about people or life in general did you have to change in order to think more like an SFBT therapist?
9. Would you be willing to participate in the follow up telephone interview? If so, please provide your contact information (telephone number and address).

Table 3.1 Email questionnaire

Data were gathered over the course of six months with two waves of data collection. After six months, I decided that I had gathered a sufficient number of responses (15) to begin analysis and generate questions for the follow-up telephone interviews. The participants' responses were analyzed to determine if common concepts or themes existed. Analysis was also conducted to determine what areas additional questioning could further develop. The questions for the telephone interview were developed from this wave of data analysis.

Telephone interview

Each of the participants who agreed to a telephone interview was initially contacted by email. This email thanked them for agreeing to participate in the follow-up telephone interviews and reiterated that their participation in this study was voluntary.

Since the telephone interview questions required more reflection and preparation for the participants to answer adequately, the email also included the interview questions and reminded the participants that these interviews would be audio recorded. Finally, the email advised the participant that the telephone interview would last an estimated 30-45 minutes and informed them that I would contact them via telephone to schedule the interview. Efforts were made to accommodate the participants' schedule as much as possible. The telephone interview questions are detailed in Table 3.2.

1. In the email questionnaire, I had asked you to describe a distinct moment or situation when something "clicked" and you felt SFBT was something you could use effectively with clients. During the phone interview, I will be asking you to elaborate on your responses, asking how did you know or what were the indications that SFBT was "clicking" for you and what effect this moment had on you and/or your client.
2. Please describe the environment in which you learned SFBT, including how many classes/workshops did you take and how often those classes met. Did your training include both learning in a classroom setting as well as a clinical setting? Did you learn SFBT in a group setting, and if so, what influence did your peers/colleagues have on your learning process. I will also be asking you to describe the atmosphere in which you learned SFBT, as well as to describe your SFBT trainer/supervisor. Finally, I would like to know if you had learned any other model of therapy in your training environment.
3. In the email questionnaire, I had asked about any philosophies/beliefs you had to change about people and their problems in order to think more like an SFBT therapist. I am interested in finding out if making these changes compromised at all your ability to do therapy with your clients.
4. Did you have anyone in your training program/workshop who dropped out or stopped using SFBT and can you speculate as to why?
5. Is there anything else you think would be helpful for me to know about learning SFBT?

Table 3.2 Telephone interview questions

After I conducted the telephone interviews, I sent three additional questions to the telephone interview participants. These questions arose after analyzing the responses to the telephone interviews. The follow-up questions I sent to the telephone interview participants were as follows: 1) Does doing solution-focused techniques in session make you a solution-focused therapist? What tells you that you are a solution-focused therapist? 2) Can you be a solution-focused therapist without using solution-focused techniques/asking solution-focused questions? 3) Does practicing solution-focused techniques help you believe in and adopt the philosophy underlying SFBT? Three participants provided responses via email to these questions.

To protect confidentiality, all of the responses from the email questionnaire and the tapes and transcripts of the telephone interviews were kept in a secure location. Additionally, all identifying information was removed from the participants' responses, to protect the identity of the participant. Only my advisor and I had access to these. All links connecting the participants' identities with their responses will be destroyed upon completion of the study.

Data analysis

The majority of the data in this study was analyzed using a modified version of the constant comparative method (Glaser and Strauss, 1967; Newfield et al, 1996). Information from the analysis of the email questionnaire responses was used to develop the questions used in the telephone interviews. Similarly, information from the analysis of each telephone interview was used to enhance the questioning for the subsequent interviews. This is consistent with the constant comparative method of qualitative research. Since the purpose of phenomenological research is to describe and understand the experience of the participants, this method of collecting and analyzing data is appropriate (Boss et al., 1996).

Although most of the data were analyzed using qualitative methods, a small portion of the data called for quantitative analysis. I calculated the range of the responses to question one in the email questionnaire, in order to provide descriptive statistics on therapist age, gender, geographic location, training and experience. Additionally, I calculated the range, median and mean of the responses to question two in the email questionnaire, in order to provide some information on how often these participants used certain solution-focused techniques in their work.

The remainder of the data collected from the email questionnaire was coded using the constant comparative method. I kept a journal during the coding process, in order to note my own reactions and emotional responses as well as any insights or questions that arose. Those insights and questions that came up from the analysis of the email questionnaire response were used to create the questions used for the telephone interviews. I looked for the presence of common concepts and themes in the participants' responses, which were explored further during the telephone interviews.

The data from the follow-up telephone interviews was analyzed in a similar fashion as the data from the email questionnaire, meaning the data was coded using the constant comparative method. Once all of the interviews were conducted and the data analysis for all of the interviews was completed, I organized the data into the overall themes and concepts that captured the essence of the participants' responses.

CHAPTER FOUR: RESULTS

Introduction

My intent for this research study was to develop an initial understanding of the process that trainees experience as they learn to do Solution Focused Brief Therapy (SFBT). Specifically, I examined what training methods these trainees found most helpful as well as what types of training environments were most conducive to their learning process. I also examined how and if trainees were able to merge their own, existing philosophies about clients and their problems with those philosophies underlying SFBT. Finally, I questioned the participants about a distinct moment they experienced which indicated to them that SFBT was a model they could use effectively with their clients. This distinct moment seemed to represent a moment when the trainees had acquired the knowledge base of SFBT and had, in some way, fit that knowledge with their existing beliefs about how therapy should be conducted.

It was my intention for the participants in this study to be trainees who consider themselves to be solution-focused therapists. The sample was intended to represent a set of individuals who successfully learned and used SFBT with their own clients. By limiting my sample to these individuals, I hoped to develop a description of what happens for a trainee when this learning process works for him/her, that is when the learning process results in the trainee's adoption and practice of SFBT.

I enlisted participants for my study by calling upon members of the Solution Focused Brief Therapy Association, a newly formed group of individuals who are interested in exchanging ideas and practices related to SFBT, especially those ideas and practices concerning the teaching and training of this model. These members were especially interested in the teaching and training methods that may further advance this model. The members of this association teach SFBT in various parts of the United States and Canada in either academic or workshop settings. The members of this association were asked to provide the names of individuals they had trained who they thought had adopted and now use this model. Eleven trainers gave me the names of thirty-one individuals who were sent an email questionnaire. Fifteen of those contacted responded to my email questionnaire and provided data about their experiences. Of these fifteen participants, seven participated in my telephone interviews.

The bulk of this chapter will describe the findings from the email questionnaire responses and telephone interviews as these represent the two primary sources of data. The major themes that resulted from the participants' responses will be presented. First, however, the demographic characteristics of the sample will be described.

Characteristics of email questionnaire participants

Of the fifteen individuals who responded to the email questionnaire, three were male and twelve were female. The participants ranged in ages from twenty-three years to fifty-four years old and reported anywhere from one to twenty-five years experience working with clients. These participants' professional backgrounds included family therapy, social work and nutritional counseling. Although there are differences in focus in these professions, all are involved in helping people to make changes in their lives and, therefore, solution focused philosophies and techniques can be used and practiced with the clientele they encounter and the setting in which they work and practice.

Characteristics of telephone interview participants

From the pool of individuals who responded to the email questionnaire, eight volunteered to participate in the telephone interview part of the study with seven interviews being conducted. Efforts were made to contact the eighth individual to schedule and conduct the telephone interview; however, these were unsuccessful. Of the seven individuals who participated in the telephone interview, two were male and five were female. Their ages ranged from twenty-three years to forty years old. Their experience working with clients ranged from two to thirteen years. Like the pool of individuals who responded to the email questionnaire, the telephone interview participants' professional backgrounds included family therapy, social work and nutritional counseling.

Quantitative results of email questionnaire participants

Most of the questions posed to the participants were open-ended questions, and therefore analyzed qualitatively. However, the participants were also asked about how often they use certain solution-focused techniques in their work. These techniques are 1) asking about pre-session change, 2) developing therapeutic goals, 3) asking the miracle question, 4) asking scaling questions, 5) asking exception questions, 6) taking a consulting break during session and 6) using compliments and giving tasks. Participants

were asked to estimate, using a Likert scale, how often they use these techniques with each client that they see, with five meaning they always use the technique and one meaning they never use the technique. Since Gingerich and Eisengart (2000) considered these techniques to be the core components of the model, I wanted to obtain some information about how often these participants use these techniques, since the sample in this study was to be limited to those who would consider themselves to have learned, and subsequently use, the solution focused model with their clients. The following table summarizes the results from this question.

	Mean	Mode	Range
Setting goals	4.7	5	3-5
Compliments/tasks	4.5	5	3-5
Exception questions	4.3	5	2-5
Scaling questions	3.6	4	2-5
Pre-session change	3.2	2, 3	1-5
Miracle question	2.7	2	2-4
Consulting break	2.1	1	1-5

Table 4.1 Quantitative results

The data on this table shows that goal setting, using compliments/tasks, and asking exception questions are the techniques identified by the participants as most often used during their sessions with their clients. Use of the miracle question and a consulting break are the techniques identified by the participants as the least used.

Qualitative results – Learning process

The participants in this study were first asked to describe the environment in which they learned Solution Focused Brief Therapy. Specifically, in the email questionnaire, the participants were asked what training methods had been most helpful in learning how to do Solution Focused Brief Therapy. Although a short answer format was required for this question, the participants were given a list of training methods, including reading, watching videos, examining case studies, doing role plays, using the model in actual therapy sessions, observing from behind the mirror as the model was being used with clients. Those who participated in the telephone interview were asked to provide more detail about their learning environment.

In general, the participants described a general process of didactic learning followed by “hands on” experience in learning Solution Focused Brief Therapy. Most

followed a progression of reading related material and discussing this material in classroom settings followed by watching the model being used, either in videos or in live cases, and then finally being able to practice techniques, either in role-play situations with other trainees or with actual clients. While many of the participants mentioned a variety of training methods they had found helpful, all of them included some mention in their responses that being able to practice the techniques associated with this model had been helpful to them in some way. The majority of the participants said that being able to practice the model was the training method they had found the most helpful. Being able to practice allowed the trainees to take the knowledge they learned in class and use it in their work with their clients. One participant gave the following response when asked what had been most helpful in learning SFBT:

"Reading, examining case studies, doing role plays, using the model, observing SFBT, and even teaching it in laboratory sessions have all been helpful to me in learning and maintaining SFBT skills. I found that one of the most valuable resources was actual practice of the method. While theory lays the foundation, it's often hard to integrate all the components of the method without actually doing it and receiving feedback on strengths and areas of improvement." (E1300)

In addition to practicing, the participants also said that having a trainer/supervisor who was knowledgeable about the model, adept at using the model, and who was supportive regarding the participants' use of the model was conducive to the learning process. While these supervisors used traditional supervision methods with these participants, such as discussion of their work as a therapist, reviewing videos of their sessions and providing feedback, some of the participants also described their supervision as being solution focused in nature. These participants described their supervisor as taking a non-expert role in the supervisory relationship. One telephone interview participant stated

"…He would pull someone from the class and do a role play with them in the front of the room and [ask] how did that work, how did that not work, what could I have done otherwise? All of us were saying, you're the professor, you know what you're talking about, but he would still make us give him feedback." (T3)

Another way in which the training and supervision was solution focused was that the trainer/supervisor built on the participants' strengths and those parts of the model they were already doing well. One email questionnaire participant stated

"Trainer/supervisor became very solution-focused in his training of the model as well, which was a nice meta-learning technique. For example, in training us, he may be highlighting our exceptions to our frustrations or feelings of lack of knowledge or understanding, as well as provide us with many compliments, and maybe just using the concepts in this way." (E1030)

One other theme that emerged from reviewing both the email questionnaire responses and the telephone interviews is that being immersed in a solution-focused environment was conducive to learning. Many of the participants said that being able to discuss the reading material as well as their clinical work with other trainees who identified with this model was helpful to them. Hearing others' perspectives seemed to enhance their learning experience, to the point where they were able to create a strong knowledge base of this model. Being surrounded by others who also believed in this model seemed to create a safe environment in which to share concerns. One of the telephone interview participants stated

"It has been easiest for me to really do Solution Focused, really to stick to the theory when I am reading, thinking about it more consciously. The more I read about Solution Focused theory, the more I go over it and think about it and read articles or read books, the more my therapy reflects, in the sense that I tend to do it more. For me…its kind of one of those things where the more I'm around people that talk about it, that use it, the more books that I read about it, the more I seem to use it with my clients…If I was to get a job, I would want to be around individuals who share that background, that perspective, because I think that would really help me to really stick to the theory and to really, in a sense, be a better therapist, since that comes naturally." (T2)

Additionally, learning in a supportive and collaborative environment seemed to prepare the participants for some of the obstacles to practicing SFBT they experienced in other settings. After leaving the training environment, the participants were often placed in settings where others were skeptical of the approach. These were settings that were more problem-focused and focused on gathering information about the problem. Additionally, these settings also had outside demands that did not mesh as well with Solution Focused Brief Therapy. One telephone interview participant responded, when asked about practicing in a setting that did not embrace this approach:

"I'm pretty confident with it because I've seen it work. There are still parts of it, that with a job like foster care, there's always a struggle. There are so many outside demands that you're accountable for, like the court and the funding for your program. They want

certain information and the court is making decisions based on certain things, and they may not always line up with what you're trying to accomplish with your clients. But I'm not skeptical of the approach or its effectiveness now." (P1)

One telephone interview participant indicated that it was easier for him to learn in a "fun" environment, that is, surrounded by others who believed in this type of therapy. However, he said that he learned more in a "hostile" environment, that is, when surrounded by those who were skeptical of this approach. He stated

" Well it was easier to learn when it was fun, but I learned more in the hostile environment because I had to justify everything I was doing. So I had to think it all through. I didn't have this group going, yeah, yeah, yeah, this is the way to go and not questioning it. I can remember going to conferences and going, hey am I nuts or what? But I had to do the homework…there was that element of I had to justify where I was coming from and what I was doing…So in the hostile environment, I really had to learn…I mean, it was tough. But I had to learn it and it was good for me." (T7)

In summary, being able to practice using a solution-focused approach with clients and receiving feedback on those sessions from a solution focused supervisor are factors that these participants identified as being most helpful in facilitating their learning process. Additionally, being immersed in a solution-focused environment seems to facilitate learning and adoption of this approach, in that this type of environment helps to create and strengthen a good knowledge base of the model's philosophies and techniques, and helps prepare the trainee for being able to successfully use this model in settings where it may not be as widely accepted.

Qualitative results – Fit between therapist and theory

Taibbi (1996) discussed the importance of a therapist's clinical work being guided by a theoretical framework that fits his/her personality, stating "good theories also fit [our] personal philosophies" (p. 8). Wampold (2001) echoed this idea when discussing the concept of allegiance to a therapeutic model. He defined allegiance as "the degree to which the therapist delivering the treatment believes that the therapy is efficacious" (p. 159). Following that line of thinking, the participants in this study were asked about the "fit" between their personal philosophies and the philosophy underlying SFBT. Specifically, the email questionnaire participants were asked to identify those personal philosophies about clients that fit with SFBT as well as identify those personal

philosophies about clients they had to change in order to think more like a solution-focused therapist. To further explore this concept, the telephone interview participants were asked if changing any of their existing personal philosophies compromised their ability to do therapy. Since the therapist's use of self is an important part of doing good therapy, I was interested to find out if changing one's own basic beliefs affected the participant's ability to deliver good therapy. They were also asked to offer speculations about others in their learning environment who did not follow a solution focused approach, and why they thought these individuals did not follow this approach. This final question was asked to gather further insight about fit between model philosophy and therapist's personal philosophy.

Most of the participants stated that their general optimism about people and their belief that people have the ability to solve their problems were beliefs that they already had that fit with the philosophies underlying SFBT. These were individuals who believed that their clients had strengths and resources and could use them to resolve their problems. These were also individuals who believed that clients were capable of changing. Given that, there was a general theme that the role of the therapist involved encouraging the client rather than directing them to make whatever changes they thought the client should make. One of the email questionnaire participants provided the following response*:*

"The belief that people can change, that they are not without hope. The belief that each client deserves and should expect a social worker who has not prejudged them and does not consider himself or herself to be the expert in any situation, especially considering that the client is much more aware of what will and will not work in his/her own life." (E1300)

Regarding the responses to the question about the personal beliefs the participants had to change in order to adopt the philosophies underlying SFBT, the participants seemed to fall into two groups. One group indicated there were some existing beliefs they had about the process of therapy that they had to change and another group stated they did not have to change any of their existing beliefs.

In the group of participants who said they had to change some of their existing beliefs, what had to change was their belief about the therapeutic process, specifically

that they should spend some time focusing on and discussing the client's problems during that process. While this shift of thinking was challenging, it was not an impossible task, since they did not have to change a core belief about people and their problems. Rather, it was their pre-existing belief about the therapeutic process that did not fit, which makes sense given that SFBT is a relatively new and different approach to therapy. One email questionnaire participant provided the following response:

"I had to change a little bit how I viewed problems…more like switching my view from seeing only the problem to finding the solutions that are already present. Highlighting the solutions already present but often hidden is difficult at times due to being so problem-focused and having a problem-mindset. The shift to seeing the solution is often difficult for therapists as well as clients, and much practice is necessary for training therapists to be able to see the good and working in some of the bad." (E1030)

There was also a group of participants who said that they did not have to change any of their existing beliefs in order to adopt the philosophy underlying SFBT. For these participants, the concepts of focusing on aspects of the client's problem, pathologizing the client or taking on the expert role were the beliefs that did not fit with how they viewed how best to help their clients. One participant said that doing other non-strength based models of therapy compromised his ability to work with his clients while another participant said that doing other models of therapy had somewhat of a negative impact on him personally. One telephone interview participant provided the following response regarding taking a problem focused approach with clients:

"I thought that's what you were supposed to do is talk out the problem, focus on that. Originally that's what I thought, before I had read anything. So I was kind of pleasantly surprised that I didn't necessarily have to do it that way. I think just the aggravation of, okay, we're focusing on [the problem], but how are we still going to get anywhere if we just dwell on the problem. I think that was the frustration. Yeah, we could talk about the problem all day, but is that really getting anywhere. So I think I was on the verge, but I didn't realize you didn't have to focus on the problem to be able to get somewhere." (T2)

The telephone interview participants were asked whether or not making these changes to their personal philosophies compromised their ability to do effective work with their clients. The purpose of asking this question was to gain more information and understanding of the participants' experiences in learning, using and adopting this model. In examining the responses to this question, there was a general consensus that making these changes, if changes were made, did not compromise their ability. Some of the

participants said that they learned about SFBT early on in their education, so that by the time they were in a position to see clients, those problem-focused thought patterns had been shifted to more solution-focused ones. For these participants, it seemed that the seed of solution-focused thinking was already present and their training experience helped that grow.

Some of the participants did not see their work with clients compromised because they continued to integrate some beliefs that did not exactly fit with SFBT into their work with their clients. Those beliefs seemed to center around giving the client information, which counters the non-expert role, or gathering information about the client's situation and problem, which counters the focus on solutions rather than problems. These participants said they would follow a solution focused approach as much as possible, but if a situation with their client warranted using these beliefs, they would not abandon their previously held beliefs about how best to help their client in order to use a pure solution focused approach. One telephone interview participant, who worked as a nutritional counselor, gave the following response:

"If they did need to know something, from an expert model, I would come out and say it. I wouldn't try to use solution focused. If they're saying, y'know, I drink a pot of coffee a day and they're going on. I say, wow, y'know, a pot of coffee is not good in pregnancy. I might ask some questions about it, like what's good about it, what's good about drinking less. But if they're pretty stubborn and strong on a point, then I'll just say, no this is the research and this is what you have to do. And then usually I say, this is the research, it's your pregnancy, do with the information what you will." (T5)

One telephone interview participant said that making changes to his own personal philosophies so that they meshed well with those underlying SFBT did not compromise his ability to do good therapy. However, he made an observation of other trainees' experiences that being overly positive and "too solution focused" can compromise one's ability to do good therapy. He stated:

"I think there's a time that people get too solution-focused when they're learning it. If you become overly positive when your clients aren't ready for that, that compromises therapy. People don't feel heard about the problem…It's like this overexcitedness about the approach, like when you're hanging around an overly optimistic person. It's kind of sickening. You can become too positive so that you don't hear the pain of clients. And then they don't feel like you're connecting with them, I suppose. And that jeopardizes

therapy…Clients have to feel heard in their problem. That's been my experience. Then you can move on" (T4).

The telephone interview participants were also asked to offer speculations about others in their learning environment, who did not follow a solution-focused approach, and why these individuals did not follow this approach. The responses to this question seemed to provide some information about what happens when there is not a good fit between therapist and theory. All except one of the telephone interview participants did have experience being in a training environment in which there were people who did not follow a solution-focused approach. The theme across these participants' responses seemed to be that other models of therapy fit better with those individuals than SFBT did and as a result, these individuals never accepted a solution-focused approach as something they could use with their clients. More specifically, there was a belief that these individuals held a more "cynical" and problem focused view of their clients and saw a solution-focused approach as not effective as other approaches. Additionally, they believed these individuals saw SFBT as a naïve approach, an approach that was too formulaic and too superficial. One telephone interview participant provided the following response:

"I had a couple students actually that have witnessed, they don't actually like the approach and they consider it too formulaic. And I agree, but I think that's getting the priorities mixed up. I think when people can look at the answers and not the questions, that then you can see the real model. I think the questions turn them off…Too superficial. Ignoring the humanity of the client, or the humanness. Sometimes I think the proponents of Solution Focused Brief Therapy don't do a good job selling the approach because they say you can ignore the problem and they say rapport doesn't matter and things like that. And that really turns people off. Because if you imagine yourself as a client, you know what it's like to see a doctor who doesn't, who sees you for five minutes and gets you out. You don't feel like a human. You feel like you're an object. And so, I think we need to go back to more of the Rogerian parts of therapy and see them as important and essential to people feeling like humans and clients feeling like subjects and not objects…I think, if the quick fix happens, it happens because there's some good work being done, but it's not because someone just used a list of questions. And the good work involves good connection with the client. Listening, knowing what the problem is, knowing what type of problem it is and then also knowing what the solution will look like and moving toward it" (T4).

In summary, the majority of the participants reported experiencing a good fit between their own personal philosophies and beliefs and those underlying SFBT. The

beliefs that did not seem to fit centered more on pre-existing notions about how the therapeutic process should take place rather than inherent beliefs about people's abilities to resolve their problems. For the participants who did make changes to their personal beliefs, so as to be more aligned with the beliefs underlying SFBT, this did not compromise their ability to do good therapy because changes were made early on in the learning process and/or previously held beliefs were simply integrated into a solution-focused framework. Regarding speculations about why others did not adopt a solution-focused approach when working with clients, the participants said that these individuals were more cynical and problem focused in their view of clients and saw the solution-focused approach as naïve, superficial and too formulaic.

Qualitative results – Distinct moments in learning SFBT

The participants in this study were asked to describe a distinct moment during or after which they felt SFBT was something they could use effectively with their clients. Additionally, the telephone participants were asked to provide more information about this distinct moment, including what exactly was it about this moment that told them this model was something they could use effectively, what effect this moment had on them, as well what effect this moment had on their client, if applicable. It was my thinking that this distinct moment seemed to represent a moment when the trainees had acquired the knowledge base of SFBT and had, in some way, fit that knowledge with their existing philosophies and beliefs about people and how therapy should be conducted. In other words, it was designed to provide a picture of how the training and learning came together in practice.

For many of the participants, the distinct moment occurred when he/she used a solution-focused technique during a session with a client and the use of this technique resulted in a specific, observable and positive change in their client. This change translated into the client becoming more thoughtful after the solution-focused question was posed in session or the client being able to make changes in their situation after a solution-focused intervention was used in session. The distinct moment also had a positive effect on the therapist, in that the moment seemed to be an indication that there was a relationship between what they were doing with their clients and changes they could see happening in their clients. There was a sense that the use of a solution-focused

approach was a new and different way of working with clients that resulted in gaining a perspective that neither the client nor the therapist necessarily expected. One of the email questionnaire participants, who is a nutritional counselor, gave the following response:

"This particularly tough customer was someone who was very negative and I could easily fall into the trap of listening to her 'poor me' story and she could talk for an hour non-stop and drag me down a black hole and we'd have said nothing about nutrition. So I called one of the outreach workers, we came up with some questions I could use (eg. Miracle question). I wrote them down, and the interview went great. I came out of the home visit feeling awesome and I remember saying to myself, 'NOW, I feel like a real dietician!" It only took 13 years! In all of my training around counseling and education and communication, nothing ever equipped me as well as SF" (E1257).

Some of the participants' distinct moments did not occur during a session or interaction they had with a client. Rather the distinct moment came as they were becoming familiar with the model's underlying concepts and ideas. There was sense that what they were learning seemed to merge well with the beliefs they already held. These participants gave responses indicating that they immediately felt SFBT was something they could use with their clients and that the use of the solution-focused techniques and interventions came naturally during sessions. One telephone interview participant described his reaction to reading a passage in Patterns of Brief Therapy, by Steve deShazer:

"I don't recall the section [of the book] as much as I remember the essence of it. Because I think I was on the fifth floor of a library at [university], and I happened to just see the book on the shelf and pulled it off and read it. And there are two things that clicked. Number one is, it was very practical. I mean it made sense. It wasn't interpretive. It wasn't a bunch of psychobabble. It just made sense. And then the second part that I remember is that it was much more about strengths…I don't know if these were the words that were used, but the message was, take a look at what's working and try to intervene in someway that way. And I thought, that makes so much more sense than everything else I've ever read or been taught" (T7).

In summary, the moments that told many of these participants that SFBT was something they could use effectively with clients occurred during a session with a client, in which use of a solution-focused concept, technique or intervention produced a specific, observable change in the client, which in turn had a positive effect on them as therapists. A smaller group of the participants knew this model was something they could use with their clients as they became more familiar with the model and as they came to the

realization that their own beliefs and philosophies merged well with those underlying SFBT.

CHAPTER FIVE: DISCUSSION

Introduction

The purpose of this study was to examine the process that trainees experience when learning how to do Solution Focused Brief Therapy (SFBT), specifically examining what training methods they found most helpful and how they integrated their pre-existing philosophies about people, their problems and the therapeutic process with the tenets of SFBT. The study also examined the distinct moments, in which trainees noticed that this approach to therapy was working for them. The distinct moment served as a marker that the trainee had successfully learned SFBT and integrated its tenets with their own pre-existing philosophies. There were two primary research questions for this study. First, what were the trainees' experiences in learning SFBT; specifically what training methods did they find most helpful when learning this model and what factors in their training environment seemed to facilitate their learning process? Secondly, what was the process the trainees experienced in fitting their own personal philosophies with those underlying SFBT?

Quantitative results

Participants were asked to estimate, using a Likert scale, how often they use certain solution-focused techniques with each client that they see, with five meaning they always use the technique and one meaning they never use the technique. In this study, participants reported they most often used development of therapeutic goals (mean score 4.7), compliments and tasks (mean score 4.5) and asking exception questions (mean score 4.3) with their clients. The techniques reported by these participants as being least used were asking the miracle question (mean score 2.7) and taking a consulting break (mean score 2.1). This finding is somewhat inconsistent with the literature. deShazer and Berg (1997), the co-founders of this model, indicated that, for research purposes, all four of the following components should be present in order to considered solution-focused: asking the miracle question, asking scaling questions, taking a consulting break, and giving compliments to clients. Gingerich and Eisengart (2000) indicated in their review of outcome research on SFBT, that only one of seven core SFBT components (goal setting, use of compliments/tasks, exception questions, scaling questions, miracle question, searching for pre-session change and use of consulting break), needed to be present in

order to be included in their review. It is interesting to note that, in the current study, the techniques reported as most often used (use of compliments and development of therapeutic goals) are common to other models of family therapy and not specific to SFBT. The two techniques reported as least often used (miracle question and use of the consulting break) are often considered to be hallmarks of SFBT. The results of the current study are contrasted with those of Skidmore's (1993) survey of graduate students, which rated the miracle question the most therapeutic among the SFBT interventions.

Although there have been parameters set for what constitutes SFBT for research purposes, there still appears to be some question about what constitutes this model in clinical terms, with the results of the current study highlighting that question. The participants in the current study were defined, at least by the trainers who referred them, as successful adopters of this model, and as such, individuals who use and practice SFBT. Yet, these participants also indicated they do not often use the techniques and interventions, which are considered to be the hallmarks of SFBT. Perhaps SFBT's underlying philosophy is more of an indicator that this model is being used, rather than the frequency of the model's techniques in sessions with clients.

Qualitative results

The results of the current study indicate, for these participants, being able to practice using a solution focused approach with their clients, while receiving feedback on those sessions from a solution-focused supervisor are factors that were helpful in facilitating the learning process. Additionally being immersed in a solution-focused environment, that is being able to discuss clinical cases with others who support and have adopted this approach, also helped to facilitate the learning process. The participants reported these factors helped create a strong knowledge base of the model and helped prepare them for being able to successfully use this model in settings where it may not be widely accepted. The participants, for the most part, described their supervisors/trainers as taking a non-expert role during supervisory sessions, and using solution-focused techniques, such as searching for exceptions and using compliments, during supervisory sessions.

The results of this study reflect the concept of isomorphism as described in the family therapy training literature (Liddle, Breunlin, Schwartz and Constantine, 1995).

The training and supervision that these trainees received are similar to the solution-focused supervision described by Wetchler (1990), Marek et al (1994) and Todd (1997). These authors described solution-focused supervision as focusing on strengths and exceptions in the trainee's clinical work as well as the use of compliments. Although Wetchler indicated that solution focused supervision could be used with theoretical orientations other than solution focused, the results of this study seem to indicate that using this type of supervision may be particularly helpful in learning SFBT. The results also confirm the statement made by Marek et al that using solution focused supervision to train therapists desiring to learn SFBT is especially useful in that this particular type of supervision is a way for SFBT to be "modeled" for the trainees.

The participants in the current study indicated that being immersed in a solution-focused environment facilitated their learning process. This seems to confirm Street's (1997) statement in his review of family therapy training research, in which he described the learning process for family therapy trainees as one in which a trainee interacts with several different elements, such as the trainer, the training methods used, the other trainees and the experiences that each brings to the environment. If the trainee is interacting with the different elements in the training environment, and many of those elements could be described as being solution-focused, it makes sense that this type of environment would produce solution-focused therapists. The results of the current study also appear to confirm the findings of Anderson, Schlossberg and Rigazio-Digilio's (2000) survey, which found that the best supervision experiences occurred in open, respectful and supportive environments.

The majority of the participants reported experiencing a good fit between their own personal philosophies and beliefs and those underlying SFBT, with mention that using non strength-based therapeutic models had some negative impact, personally as well as professionally. For some of the participants who did make changes to their personal beliefs, so as to be more aligned with the beliefs underlying SFBT, this did not compromise their ability to do good therapy because previously held beliefs were simply integrated into a solution focused framework. Regarding the distinct moments that told these participants that SFBT was something they could use effectively with clients, many of these occurred during a session with a client, in which use of a solution-focused

concept, technique or intervention produced a specific, observable change in the client, which in turn had a positive effect on them as therapists.

The results of the current study support the writings of Taibbi (1996) and Wampold (2001), both of whom indicated that a therapist is likely to choose a theoretical framework from which to operate that is aligned with their own personal beliefs about people, the development of mental health problems and the process of change. The majority of the participants described themselves as fairly optimistic people, who believed that their clients possessed the necessary resources to resolve their problems. These beliefs are included in the philosophies, which underlie SFBT. The participants also indicated that use of other non-strength based models had a negative personal impact and so influenced their ability to do good therapy. Wampold also discusses the distinction between allegiance to a model, in which the therapist believes the therapy being delivered will be beneficial to the client, and adherence to a model, in which a therapist uses interventions associated with one model, as opposed to another model.

Past research on SFBT indicates that use of this model can have a positive effect on the therapist, the work environment as well as the client (Clark, 1996; Corcoran, 1999; Kok and Leskela, 1996; Triantafillou, 1997). The positive effects include the therapist feeling less overwhelmed by their work, a brighter, more positive work environment, and more of a feeling of empowerment for both therapists and clients to cope with difficulties. The results of the current study appear to confirm this part of the literature, in that many of the distinct moments described by the participants involved a positive effect on the therapist and client after use of the model in session. Also, the results regarding fit between therapist and theory also confirm this past research, if operating under the assumption that a good fit between therapist and theory can be equated with a positive effect on the therapist.

Past research on SFBT also indicates that this is an approach that could be easily integrated with existing approaches, which are not necessarily strength-based or client centered (Clark, 1996; Osbourn, 1997; Kok and Leskela, 1996). The results of the current study confirm this in that many of the participants reported integrating non-SFBT practices, such as giving information to the client or gathering information about the client's problem, in their work with their clients. The results of this study appear to

indicate that therapists, even those who would define themselves as following a solution focused orientation, still experience situations which would warrant straying from using a pure solution focused approach, and that integration in these instances can happen without being problematic. The participants in this study were also practicing this model with their clients in real clinical settings. Therefore, they were all in a position to give some insight into, not only how this model is best learned, but also how SFBT can be practiced realistically with clients.

In fact, strict adherence to a therapeutic model could result in poor therapy being delivered to clients. Nylund and Corsiglia (1994) discussed the difference between using solution-focused therapy and using "solution forced" therapy when working with clients. The authors contend "solution forced" therapy can occur when the therapist solely uses the solution-focused techniques to the point where the client's needs may be ignored. This could occur when there is no acknowledgement of the client's pain, when the therapist ignores a salient exception to the client or when the therapist does not consider the client's reasons for seeking therapy. The authors contend that an enthusiasm to use the techniques could result in the failure to follow some of the model's key components, such as using what the client brings to the session as a resource and honoring the client's point of view. One telephone interview participant expressed this sentiment, by reporting his experience of working with others who appeared to be "too solution focused", which in his opinion compromised their ability to do good, effective therapy. This participant's responses appear to reflect the statements made by Nylund and Corsiglia regarding "solution-forced" therapy.

Follow-up email questions

After the conclusion of the telephone interviews, three additional questions were sent to the telephone interview participants. These questions arose after analyzing the responses to the telephone interviews and were related to the clinical definition of SFBT. Although definitions of SFBT for research purposes exist, there is still debate regarding what are the necessary components of SFBT clinical work. That is, what should a therapist be saying, thinking or doing in order to be considered solution focused. To begin to explore this, a follow-up email questionnaire in this study was sent to the telephone interview participants. The questions were as follows: does doing solution

focused techniques in session make you a solution focused therapist, what tells you that you are a solution focused therapist, can you be a solution focused therapist without asking solution focused questions and does practicing solution focused techniques help you believe in and adopt the philosophy underlying SFBT. Three participants provided responses to these questions. All three individuals indicated that merely asking solution focused questions and using the techniques and interventions associated with this model does not make one a solution-focused therapist. These individuals also indicated that adopting the theory behind the model is the better indicator that one is practicing SFBT. As one individual stated, "What tells me that I'm a solution focused therapist is the relentless commitment to the 'posture' of believing in the good in people, having patience with the process, and helping clients see the resources in themselves" (F2). These three individuals also indicated that, for the most part, using the techniques associated with this model will most likely follow if the therapist is using the theory underlying SFBT when conceptualizing cases and working with clients. These responses also reflect that practicing the techniques can, but may not always, lead to adoption of the model's underlying philosophy, and that factors such as fit between theory and therapist may play a role in this process.

The responses for the follow-up email questions seem to confirm the study conducted by Metcalf et al (1996), that examined the differences between client and therapist perceptions of SFBT. The authors of that study indicated there was general support for SFBT, but that an emphasis on the client-therapist relationship, rather than on the use of solution-focused techniques, may better account for the support of this model.

Implications for training

The purpose of this study was to examine the process that trainees experience when learning SFBT. As a therapeutic model, SFBT represents a departure from other family therapy models in theory and in practice. Additionally, past research has indicated this approach to therapy can be used with different populations presenting with a variety of problems as well as support for the effectiveness of this model. Because of these reasons, teaching future family therapists about SFBT and training and supervising them to use and practice this model would benefit the field of family therapy. The participants in this study provided a glimpse into how the model is currently being taught, and what

their experience was with that process. Basically, the current process of training and supervision of SFBT is by use of solution-focused supervision. The participants indicated this worked for them in learning this model's theory and practicing its techniques and interventions.

The majority of the participants in this study described themselves to be fairly optimistic people who believed that clients possessed resources, which could be used to resolve their difficulties. Prior to beginning training and supervision in SFBT, they appeared to possess, in raw form, at least some of the theoretical philosophies underlying this model. While these participants did not themselves experience major problems with using and practicing this model, some made comments concerning the emphasis in training on this model's techniques and interventions over the model's theoretical assumptions and philosophies. Other authors have voiced these concerns, with some studies indicating negative impact on clients when adherence to techniques is valued over the therapeutic relationship. While solution-focused techniques have become a hallmark of the model, and part of what differentiates it from other family therapy models, training and supervision of SFBT should not solely focus on technique, at the risk of producing "solution-forced" therapists. An emphasis on the model's theoretical philosophies and assumptions should be the foreground in which training and supervision in this model takes place.

For the participants in the current study, some parts of solution-focused philosophy were already present in their worldview prior to beginning training and supervision in this model. For them, it appeared that being able to practice the techniques associated with this model was helpful. However, how does one teach this model to someone who does not already possess at least some parts of solution-focused philosophy? The process of teaching a model's philosophy and allowing trainees to practice thinking which uses that philosophy can be complicated, considering that each trainee brings with him/her a unique worldview and set of experiences.

Implications for research

The current study provided an insight into how some trainees currently experience SFBT training and supervision and what they found helpful in that process. Street (1997) and Deacon and Piercy (2000) discussed the importance of not only considering the

perspective of the trainee in family therapy training research, but also using qualitative measures to explore this aspect. Further studies which examine the trainee's perspective and considers that perspective regarding what is and is not helpful regarding training and supervision may help to fill some of the gaps in family therapy training research. For example, universities and/or training facilities could conduct interviews with trainees at regular intervals during the course of the training program and ask them to comment of aspects of their training environment. Conducting interviews during the course of the training program may help provide data regarding the developmental process that the trainee experiences and track any changes that may occur during that process.

The question of what constitutes SFBT in clinical terms arose during the completion of this study and was minimally explored by a follow-up email questionnaire. The results of the current study indicate that the underlying philosophy of SFBT may be more of a clinical indicator, than the model's hallmark techniques. Examining this issue further may help to define this model further, in terms of clinical practice. It would also be helpful in terms of training and supervision. For example, a study could present participants with taped solution focused and other types of therapy sessions and question participants on the differences seen between a solution-focused therapy session and some other type of therapy session. Alternatively, therapists who define themselves as practicing SFBT could be surveyed regarding what they believe the clinical definition of SFBT is.

The participants in the current study seemed to enter their respective training programs with parts of the solution-focused philosophy already in their worldview. For many of these individuals, adoption and practice of this model came somewhat naturally. It would be interesting to examine how and if successful adoption of this model occurs for an individual who enters the training program without a solution-focused worldview. For example, trainees could be questioned about their worldview and about their theoretical orientation. The study could look at whether those who did not have a solution-focused worldview did ultimately adopt and practice SFBT and further interviews could be conducted with those trainees. It would also be interesting to examine the differences between those training programs, which emphasize technique over philosophy and those that emphasize philosophy over technique. For example,

trainees could be divided between two training programs in SFBT, one which emphasizes philosophy and the other which emphasizes technique. Trainees could be surveyed following completion of the training programs regarding their experiences and their beliefs about the knowledge they gained. A study could also survey the clients of the trainees and look at the differences between the two types of training programs as related to client outcomes.

Limitations of study

The current study examined the learning process that a very specific sample of trainees experienced. These were individuals, referred by their trainer/supervisor as successful adopters of SFBT. There was no definition given as to what a successful adopter of SFBT should be. Additionally, the responses given to the question posed to determine if the current sample of participants were, in fact, practicing SFBT, did not provide definitive results that would indicate the participants were successful adopters of SFBT. Further research exploring what defines a solution-focused therapist and what constitutes solution-focused practice may be beneficial in informing the field of family therapy in terms of training and clinical practice.

The current sample of participants was referred by their trainer/supervisor. Most of the participants provided a glowing report for the supervision and training they had received, in particular complimenting the work of the trainer/supervisor. The informed consent of the study guaranteed confidentiality of the results as well as guaranteed that each participant's response could not be connected with their identity, and therefore the trainer that referred him/her. However considering the overwhelmingly positive support for the trainers, which was reflected in the results, one wonders if the referral process had an effect on the results of the study. Perhaps a study enlisting participants, which does not involve referral from the trainer, may provide more sound results without this limitation.

Finally one other limitation of this study was the use of the email questionnaire. Sending the questionnaire electronically to the participants and allowing them to respond electronically was both convenient and cost-effective. However, I experienced difficulty in receiving an adequate number of responses from my participant. Two recruiting waves were necessary to get an adequate number of referrals and several efforts were made to

contact the participants to urge them to respond. Despite these efforts, only half of the questionnaires sent were returned with responses. Additionally, some of the email responses contained brief responses and lacked rich data, with much of the detailed data coming from the telephone interviews. A study employing instant messaging or group chat methods to communicate with participants would still be a convenient and cost-effective way for participants to respond and may have resulted in richer, more detailed responses.

Conclusion

The current study provided a glimpse into how trainees currently experience SFBT training and supervision and what they found helpful in that process. There were some questions that arose during the completion of this study regarding what constitutes SFBT in clinical practice and whether there should be more emphasis on the model's theoretical philosophies rather than its hallmark techniques when teaching and learning this model.

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APPENDIX A

Informed Consent of Participants in Research Projects Involving Human Subjects

Title of Project: What works when learning Solution Focused Brief Therapy: A qualitative analysis of family therapy trainees' experiences
Investigator: Elnora D. Cunanan and Eric McCollum

I. Purpose of this Research

The purpose of this study is to qualitatively examine the process that trainees experience when learning Solution Focused Brief Therapy (SFBT) as an approach to therapy. Specifically, what training methods are most effective when learning SFBT and what are the critical moments that indicate to the trainee that SFBT is an approach they could use effectively with their clients. This study will also ask trainees about their own beliefs and philosophies concerning people and their problems and how these fit (or do not fit) with the philosophies underlying SFBT. This study could inform the practice of family therapy by examining these areas, especially in the area of training.

II. Procedures

Participants will be asked to complete a short questionnaire, which will be sent to them via email. They will be asked to send their responses to this researcher electronically. It is estimated that the email questionnaire will take between 30 and 45 minutes to complete. Those participants willing to take part in follow up telephone interviews will be asked to send their contact information along with their response. Participants will also be given the opportunity to provide feedback once the data analysis of the email questionnaire is complete.

Those participants who indicate they are willing to take part in the follow up telephone interview will be advised of the research questions prior to the actual interview, in order to reflect and prepare their responses. Efforts will be made to accommodate the participants when scheduling the time and date for the telephone interview. It is estimated that the telephone interview will take between 30 and 45 minutes to complete. The telephone interview will be audio recorded and transcribed and participants will be given the opportunity to review the transcripts of the interview to note any additions, corrections or deletions and to provide any feedback.

Participation in this study is completely voluntary.

III. Risks

It is not believed that this study will present any risks to the participants.

IV. Benefits

By participating in this study, the individuals may directly benefit in that they would be given an opportunity to voice their perspective regarding what they found to be helpful in learning this model of therapy. That opportunity to voice their perspective may also enhance their belief in this model, which may, in turn, contribute to their growth as a therapist.

V. Extent of Anonymity and Confidentiality

To protect confidentiality, all emails that are received from the participants will be copied into a secured file. The original email will then be deleted. Once a completed questionnaire is received, a number will be randomly assigned to it, so that during data analysis, the participant's name cannot be associated with his/her responses. Since participants will be asked to elaborate on their responses from the email questionnaire during the telephone interview, a spreadsheet will be maintained, which will include the names, contact information and randomly assigned number of those individuals who indicate a willingness to participate in the follow-up telephone interview.

Additionally, all tapes and transcripts of the in-depth interviews will be kept in a locked cabinet. Only my advisor and myself will have access to these. These will be destroyed upon completion of the study. In writing the results of this study, efforts will be made to protect the identity of the participants, such as changing names and disguising the identifying details of their experience to a certain extent.

VI. Compensation

No monetary compensation will be given to individuals for participating in this study.

VII. Freedom to Withdraw

Participants are free to withdraw from this study at any time without penalty. Participants are also advised that they are free not to answer any questions in the email questionnaire or telephone interview.

VIII. Approval of Research

This research project has been approved, as required, by the Institutional Review Board for Research Involving Human Subjects at Virginia Polytechnic Institute and State University, by the Department of Human Development.
IRB Approval Date: Approval Expiration Date:

IX. Participant's Responsibilities

I voluntarily agree to participate in this study. I have the following responsibilities:

- Read and respond to email questionnaire
- Provide contact information and participate in telephone interview, if I wish to do so.

X. Participant's Permission

I have read and understand the Informed Consent and condition of this project. I have had all my questions regarding this study answered. I hereby acknowledge the above and give my voluntary consent. By responding to the email questionnaire, I am agreeing to this Informed Consent.

Should I have any pertinent questions about this research or its conduct, and research subject's rights, and who to contact in the event of a research–related injury to the subject, I may contact:

Elnora Cunanan	ecunanan@vt.edu	703-538-8355	Investigator
Eric McCollum	e.mccollum@vt.edu	703-538-8463	Faculty Advisor
Karen Rosen	krosen@vt.edu	703-538-8461	Departmental Reviewer
David M. Moore Chair, IRB Office of Research Compliance Research & Graduate Studies	moored@vt.edu	540-231-4991	

This Informed Consent is valid from July 9, 2002 to July 9, 2003.

APPENDIX B

Virginia Tech
VIRGINIA POLYTECHNIC INSTITUTE AND STATE UNIVERSITY

Institutional Review Board
Dr. David M. Moore
IRB (Human Subjects) Chair
Assistant Vice Provost for Research Compliance
CVM Phase II - Duckpond Dr., Blacksburg, VA 24061-0442
Office: 540/231-4991; FAX: 540/231-6033
e-mail: moored@vt.edu

MEMORANDUM

TO: Eric McCollum HD 0416
Elnora Cunanan HD 0416

FROM: David M. Moore

DATE: August 7, 2002

SUBJECT: **Expedited Approval** – "What works when learning Solution Focused Brief Therapy: A qualitative analysis of family therapy trainees' experiences" – IRB # 02-391

This memo is regarding the above-mentioned protocol. The proposed research is eligible for expedited review according to the specifications authorized by 45 CFR 46.110 and 21 CFR 56.110. As Chair of the Virginia Tech Institutional Review Board, I have granted approval to the study for a period of 12 months, effective August 5, 2002.

Approval of your research by the IRB provides the appropriate review as required by federal and state laws regarding human subject research. It is your responsibility to report to the IRB any adverse reactions that can be attributed to this study.

To continue the project past the 12 month approval period, a continuing review application must be submitted (30) days prior to the anniversary of the original approval date and a summary of the project to date must be provided. My office will send you a reminder of this (60) days prior to the anniversary date.

cc:File
Department Reviewer: Karen Rosen HD 0416

VITA

Elnora D. Cunanan
1200 South Courthouse Road #430 Arlington, Virginia 22204
703-920-3632 (home) 703-627-9272 (cell) elliecunanan@hotmail.com

EDUCATION:

Virginia Polytechnic and State University – Northern Virginia Center, Falls Church, VA
M.S. in Human Development
Concentration in Marriage and Family Therapy, August 2003

George Mason University, Fairfax, VA
B.A.in Psychology, May 1993

CLINICAL EXPERIENCE:

Student Intern-Emergency Services *August 2002 to May 2003*
Prince William County Community Services Board, 7969 Ashton Avenue, Manassas, VA
Provided therapy, mental health services and case management to individuals and families, largely applying a brief, solution-focused approach. Conducted assessments, which included providing a multiaxial DSM diagnosis, identifying problem areas and stressors, risk issues and family, social, employment, legal and psychiatric and substance abuse history. Developed and implemented treatment plans, which addressed treatment goals and objectives, and reassessed same when appropriate. Conducted risk assessments and provided short-term crisis intervention for those clients who were experiencing a mental health emergency. Discussed safety planning and/or hospitalization with clients when suicidal and/or homicidal risk was apparent. Conducted initial intake interviews by telephone for those individuals requesting counseling services, which included determining appropriate modality of treatment and making referrals when necessary. Collaborated with other therapists, psychiatrists and other mental health professionals in order to coordinate services for clients when appropriate. Fulfilled administrative duties and maintained client files, according to agency guidelines.

Family Therapist Intern *May 2001 to June 2003*
Center for Family Services, 7054 Haycock Road, Falls Church, VA
Provided therapy, mental health services and case management to individuals, couples and families, largely applying a brief, solution-focused approach. Conducted assessments, which included providing a multiaxial DSM diagnosis, identifying problem areas and stressors, family strengths/assets and risk issues. Developed and implemented treatment plans, which addressed treatment goals and objectives, and reassessed same when appropriate. Participated in case planning sessions with supervisor and other therapists, in which cases were discussed and collaborated. Collaborated with other therapists, psychiatrists and other mental health professionals in order to coordinate

services for clients when appropriate. Fulfilled administrative duties and maintained client files, according to AAMFT guidelines.

Student Intern *June 2002 to August 2002*
Counseling and Forensic Services, 1308 Devils Reach Road, Suite 310, Woodbridge, VA
Co-facilitated four Relapse Prevention Groups for court-ordered sex offenders with a Certified Sex Offender Treatment Provider, using a cognitive-restructuring approach. Attended monthly meetings with other treatment providers, probation officers, polygraph examiners and law enforcement officers to collaborate and coordinate services for group participants.

Hotline Volunteer *March 1997 to June 1997*
Victims Assistance Network, 8350 Richmond Highway, Alexandria, VA
Provided short-term crisis intervention for victims of domestic violence or sexual assault, making referrals for ongoing counseling when appropriate.

Probation and Parole Officer *August 1994 to August 2000*
Virginia Department of Corrections, 9309 Center Street, Suite 204, Manassas, VA
Investigated backgrounds and prepared reports of those individuals being sentenced by the Prince William County Circuit Court, including assessing circumstances and providing recommendations regarding the individual's need for mental health and/or substance abuse counseling. Monitored adult offenders who have been placed on community supervision, which included providing counseling, conducting home and office visits, conducting criminal record checks and conducting periodic urinalysis for illegal substance abuse. Reported any violations of the conditions of community supervision to either the Prince William County Circuit Court or Virginia Parole Board, making recommendations when appropriate.

PROFESSIONAL ORGANIZATIONS:

American Association for Marriage and Family Therapy, Student Member since Jan 2001
Solution Focused Brief Therapy Association (SFBTA), Member since October 2002
Scheduled to co-lead discussion group at 1st annual SFBTA conference at Loma Linda University in Loma Linda, California November 2-3, 2003.