Thesis: Doctor of Counselling Psychology

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March 2001

This thesis is dedicated to my late father and my mother,

Oscar and Barbara Spitzer.

To you I owe everything!

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Acknowledgements

"I get by with a little help from my friends"

Beatles, 1967

This thesis is a collaborative project that reflects the help, support, and inspiration of my colleagues and friends who have contributed in many ways to its completion. The named individuals here are a small sample of the people who have encouraged me to complete this work.

First, I would like to thank Bryan Adams of City University for his support in the development of the project and his unbiased opinions in relation to the topic matter. His distance from the subject matter, Solution Focused Brief Therapy, gave me clarity.

I would like to thank the sixteen therapists who painstakingly collected the data from subjects. Without their commitment this thesis would not have been possible. Their enthusiasm for the research was infectious and greatly appreciated.

I would also like to thank the numerous therapists that have inspired my practice and me over the years, especially my colleagues John Sharry and Brendan Madden at the Brief Therapy Group in Dublin, Ireland. It is through discussion with these colleagues that many of the ideas presented were developed. These colleagues have challenged me to achieve and supported me every step of the way.

I would also like to acknowledge my husband Tim, who daily teaches me about life and love.

Finally, I would like to thank all my clients over the years. Their strength and motivation in searching to overcome their problems inspires me continuously.

This thesis has been a long journey, I thank you all!

Introduction: Doctor of Counselling Psychology

Personal and Professional Context

The way people behave and change has always fascinated me. From an early point in my education I was interested in psychology and the human condition. I started a Bachelors Degree in psychology in America and was introduced to many different disciplines ranging from research into perception to carrying out psychometric testing. I emerged from the completion of this degree with the firm knowledge that it was psychology applied to human change that was my primary interest. I enjoyed the challenges and rewards of working with people and this led me to start a two-year full time Masters programme in counselling psychology in the autumn after my graduation. I was keen to develop the professional and personal skills required to engage with clients in a meaningful way. This Masters course was eclectic in its approach and introduced me to a wide range of therapeutic models, particularly focusing on Client Centred and Adlerian counselling. In hindsight, I feel that this period of my education was the most challenging in my life, demanding a high level of submissions in addition to self-reflection and personal development. A central part of the Masters was a year's internship working with clients under clinical supervision. I was given the opportunity to complete this in London working part time in a hospice counselling service and part time developing an internal counselling service for an international recording

company in the UK. This was a great opportunity and I jumped at it with lots of energy and enthusiasm, if no experience.

I enjoyed the work within the hospice with both patients and families. This included developing bereavement groups and writing information literature about the service provided and the different stages of bereavement and dying. I learned several valuable lessons during this period: the importance for people to have meaning in their death and the importance of professionals to be able to be creative in providing a service that was useful to people in their own individual way. I will forever be grateful to one man that I had the pleasure of knowing who was terminally ill with cancer. Far from just having formal counselling sessions, this man taught me how to be flexible and to respond to his needs. In his healthier days his main social outlet revolved around a local betting shop in his village. Once a week he would meet his friends there and talk through the afternoon while making his bets (and sometimes even winning). During his physical decline he was confined to a wheelchair and was too embarrassed to continue to attend his weekly meetings with his friends. In discussion with him about a meaningful life until his death, he decided that it was more important for him to continue to engage in the things that he enjoyed in life, including his weekly bet. I accompanied him the first time to the betting shop to help him "navigate" the streets in the wheelchair and to ensure he would be able to access the shop. Once he gained confidence and support from his friends (who did not even

know of his diagnosis before he arrived in the wheelchair) he felt he had found a way to keep this important aspect of his life going even in the face of death. This man taught me several valuable lessons, particularly the importance of listening to what clients want, being creative and flexible in helping them achieve their wish, and then learning to move away when they have found their own strength in their way forward.

Although I enjoyed that work at the hospice I became aware that my real passion was with the work within organisations and developing the many different skills required to perform this role: counsellor, trainer, manager, and promoter to name but a few. After the completion of my internship I was offered a full time position within the same company, and once again I jumped at the chance. I became a full time internal employee assistance counsellor, managing the service and providing training and clinical work for the employees. I began educating myself in this field by joining professional organisations like, Employee Assistance Professionals Association (EAPA), and signing up for training in the skills that I would need to fulfil the job.

One of my main concerns was the lack of training I had in short-term counselling and therapy. Employee Assistance work revolves around short-term interventions and if long-term counselling is necessary, clients are referred on to other agencies. In the contract I was servicing, the employees were entitled to a limit of six counselling sessions (which would be common practice for most EAP

programmes). Although my training in counselling was diverse and included a wide section of models, it did not focus on how to offer the best intervention for a short-term therapeutic contract. In searching for training in these types of models; I was introduced to a group in London called the Brief Therapy Practice, who provide training in Solution Focused Brief Therapy and subsequently attended a four-day introductory training course with Chris Iveson. This introduction and the following training changed my therapeutic work forever. In the solution focused model I found a home. The basic assumptions of the model - encouraging the client to be the expert on change, focusing on strengths, and looking towards the future - were values that I already held as a therapist. This model seemed to not only make sense to my beliefs as a person, but also fitted the context of the service I was providing in my work.

I began to read about the history and development of these therapeutic ideas and attended numerous workshop and lectures on the model. Whenever there was a possibility to talk to "experts" in solution focused therapy, I took it and began to expand my knowledge of the field. I was fortunate enough to be invited to be part of the reflecting team for therapists practising in the model and began to see the model in action and felt the energy generated by the practice of "positive thinking" about clients. As I expanded my knowledge I began to practice the model with my own clients and began to see the impressive results. I had found my therapeutic home.

Given my strong interest in the model of Solution Focused Brief Therapy, I was keen to make it the basis of my doctorate. When talking to other professionals about my interest in the model and other brief therapeutic ideas I was often asked to back up my preference for the intervention with research to prove its validity and I hoped to take on this challenge by designing the outcome study described in Section B of this thesis.

In more recent years I have been fortunate enough to be part of a team of therapists in Dublin, Ireland. Our team is dedicated to the development of strength based therapeutic interventions and the development of research and writing in the field of psychotherapy. Our group - Brendan Madden, John Sharry, and myself - has made a commitment to making training in short-term models of therapy accessible to professionals in the Republic of Ireland. We have been conducting training ourselves, inviting discussion of the application of these ideas and encouraging collaborative projects that provide assistance for clients and new energy for professionals. In the last year we have specifically developed Employee Assistance Programmes for companies in Ireland and thus I have been able to draw on my experience in London.

The thesis, as a whole, pulls together my work as a professional, particularly my interest in short-term models of therapy and Employee Assistance Programmes (EAP). These two interests also overlap in that most of the therapeutic interventions carried out

within EAP clinical work are short-term models. Most EAP providers are looking for clinical practitioners who are able to provide future focused, goal-oriented interventions to employees that seek their help. The solution focused model is a perfect match to integrate with the organisational services. This match is not only the focus of my thesis but also the area of psychology that I continue to investigate and expand my knowledge in.

Overview of Thesis Sections

Section B: Research

This section describes the design and implementation of an outcome study into the effectiveness of Solution Focused Brief Therapy with 40* clients attending 16* therapists and using a standardised instrument (the Coping Resources Inventory) to measure change. As the model is relatively new, developed in the early 80's and formalised in 1986 with its first descriptive article (de Shazer et al., 1986), there are few previous studies, especially those that have used standardised measures.

Though the current study had a number of design problems, particularly the validity of the testing instrument and a small sample size, there were some interesting findings. In particular the study found that 1) that unemployed subjects improved significantly more than employed subjects on some measures, 2) that problems relating to "self" improved significantly more than problems relating to

"relationships", and 3) that clients and therapists perceived difference both in what they thought was helpful during the sessions and what they perceived actually happened during the session. The section concludes with inviting more research and suggests standardised instruments that may be more useful in future investigation.

Section C: Case Work

This section of the thesis develops a single clinical case exploring three aspects of my professional experience: Solution Focused Brief Therapy, bereavement counselling, and employee assistance counselling. The case presented is of a young woman who lost a boyfriend to suicide and refers herself to her employer's counselling service. This case demonstrates the use of solution focused work with a presenting problem usually reserved for more long-term support. The circumstances demonstrate the parameters of employee assistance work and how a practitioner can work within these constrains and still provides meaningful and productive therapeutic interventions. The presentation also highlights the ability to have the client be the expert on change, build strengths with the client, and remain future focused in a time of great loss and distress.

Section D: Critical Review of Literature

The development of Employee Assistance Programmes (EAP) in the United Kingdom is reviewed and the research supporting the use of these programmes in organisations is presented. The various ways to implement a programme are explored, compared, and contrasted. This section suggests ways forward for the profession to continue to expand and provide quality programmes that are a benefit to both individual employees and the larger organisation.

An Outcome Study of Solution Focused Brief Therapy

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Abstract

This paper develops the model of Solution Focused Brief Therapy, reviews the historical research on the model, and outlines a research project done within the United Kingdom to measure outcomes of the model across different clients and therapists. The research measures the improvement of coping resources of subjects using the instrument the Coping Resources Inventory (CRI) at several intervals: before the start of the counselling intervention, the fourth session, and at a three-month follow-up after termination. The conclusions suggest that the model tends to be more effective with problems relating to self than relationship, that clients and therapists perceive the process of therapy differently, and questions if the Coping Resources Inventory is a valid instrument.

An Outcome Study Of Solution Focused Brief Therapy

Though having great relevance to individual therapy, Solution Focused Brief Therapy (SFBT) was originally developed within the Family Therapy field by Steve de Shazer, Insoo Kim Berg and their colleagues in the Brief Family Therapy Centre, Milwaukee, USA, in the late 70's and early 80's (de Shazer, 1985; de Shazer, 1991; de Shazer & Berg, 1988; de Shazer et al., 1986). They drew heavily on the work of Milton Erickson and also the team at the Mental Research Institute (MRI) in Palo Alto, California (Bateson, 1956; Haley, 1963; Miller, Duncan, & Hubble, 1997; Weakland, Fisch, Watzlawick, & Bodin, 1974).

Erickson was an innovative medical doctor and hypnotherapist who had moved away from problem focused and insight focused therapies to develop a range of creative strategies to help people change in the direction of their goals (Zeig, 1985) (Erickson, 1954) . The MRI team was also interested in the study of change in human systems and in how problem patterns of communication could be resolved briefly and effectively (Bateson, 1956; Haley, 1963; Weakland et al., 1974). Developing from these ideas, de Shazer's key innovation, using some of the ideas developed at MRI, was to change the focus of therapy from problem resolution to 'solution building'. This gave Solution Focused Brief Therapy its unique focus and starting point.

SFBT is not an 'expert therapy'; it is quite atheoretical. Unlike other approaches it does not have a model of human nature or a model of problem formation and development. De Shazer, particularly in his later writings, describes it simply as a way of talking with people – namely 'solution talk' – which has the effect of helping people be focused in the direction of their goals (de Shazer, 1984). This makes SFBT practical and easily adaptable by practitioners into a variety of work situations. SFBT possesses both a set of therapeutic assumptions and a range of therapeutic techniques, which can have powerful implications when applied to clinical practice. This introduction to the model will first describe the assumptions on which SFBT is based and then develop some of the techniques associated with the implementation of the model.

Assumptions of the Solution Focused Brief Therapy Model

SFBT does not argue that its assumptions are 'true' or that they can be 'proved'. Coming from a post-modern perspective, it is as impossible to prove these assertions, as it is to prove traditional assumptions of therapy from which they radically differ (Freud, 1949). The focus in Solution Focused Brief Therapy is on practical utility and usefulness. SFBT argues that the following assumptions are more useful and practical in doing brief therapy with clients. The proof is the application of the model. Assumptions should be applied consistently and for clients and therapists to judge whether they have been helpful.

SFBT differs from traditional psychoanalytic psychotherapy therapy in three distinct ways: firstly, in how change is perceived. In many traditional therapies problems are seen as fixed patterns of behaviour and human systems are often described in terms of stability or stasis. It is argued that real change takes time and that serious problems may take years to shift (Freud, 1949). In SFBT, conversely, change is considered inevitable and something that is in fact happening all the time. Within SFBT problems are seen as constantly changing and always subject to 'exceptions' – times when the problem occurs less frequently or not at all. This implies that change can happen quickly, even in problems that have existed for long periods.

Secondly, SFBT prefers to focus on the aspects of clients which differ from traditional therapy in three distinct areas: solutions rather than problems; future as opposed to past, and client strengths as opposed to weaknesses. Many therapies are problem focused, arguing that the problem/pathology needs to be identified and described before it can be solved or treated successfully. SFBT, on the other hand, argues that what constitutes the solution is often independent of what constitutes the problem. The reasons why a person comes out of a period of depression may be very different from the reasons that may have initially caused the depression. In addition, solution focused thinking suggests that there are dangers in concentrating on the problem. For some clients, focusing on the problem can be definitely unhelpful, making them feel more depressed and helpless (Miller, M., &

Duncan, 1998). On the other hand, in SFBT thinking, it is generally seen as more helpful to focus on the preferred future rather than the past problem. Therapists working from psychoanalytic models believe that professionals need to know about the cause of the problem and the detailed history of its emergence before a solution can be generated.

SFBT disputes this, arguing that it is more efficient to build a detailed and rich picture of the client's goals and their preferred future rather than dwell on the unwanted past or indeed a future dominated and controlled by past problems. Similarly, it is more helpful to focus on strengths, skills and resources rather than pathologies or deficits.

Psychodynamic approaches argue that there is no point in treating the symptoms until the therapist has discovered the underlying cause of the problem. Hence, the professional needs to know the full extent of the client's pathology and deficits before they can help the client. SFBT, however, believes that problems do not *necessarily* represent underlying pathology, but are simply struggles which the client wants to do without. In addition, clients solve their problems using their personal strengths, not their weaknesses. Therefore, in the search for a solution to their problems, it is far more important to help clients identify, marshal and build upon their own pre-existing resources, strengths and skills rather than seek to identify assumed underlying pathology.

The third way that SFBT differs from traditional models is the emphasis on adapting the therapeutic approach to fit the client's own unique way of 'co-operating' with the therapist in the task of solving his or her problem. Traditional therapies often portray clients as 'resisting' therapy and/or being ambivalent to change (Freud, 1949). Within SFBT this is thought to be an unhelpful concept. Resistance, a concept fundamental to the practice of psychoanalysis, is defined as anything that works against the progress of therapy and prevents the client from producing previously unconscious material, protecting the client from anxiety provoking thoughts. Resistance refers to any idea, attitude, feeling, or action (conscious or unconscious) that fosters the status quo and gets in the way of change. The psychoanalytic therapist's role is to point out the resistance to material and the client must then confront it if they hope to deal with conflicts realistically (Corey, 1991). Although this concept is a corner stone of the psychoanalytic practice, it is only a concept. These ideas of describing or defining behaviour and change have developed into a belief that resistance exists, like a table exists. Therefore this concept moves from a concept to a reality. The belief that resistance is a thing that must be hunted out, pointed out and confronted is not thought to be helpful in SFBT. In SFBT it is believed that this is only a way of describing behaviour and that it would be more helpful to hold a more collaborate concept with the client. Instead of the therapist being the

expert who points out resistance to material, SFBT looks for ways to work in partnership with the client.

In the SFBT model what is perceived as 'resistance' is reinterpreted as the therapist misunderstanding the client's goals or not developing an adequate alliance with the client. In SFBT, the focus is always on examples, however small, of the client's cooperation and willingness to change towards their goals rather than 'resistance'.

It is the job of the therapist to focus on the client's 'unique way of cooperating', and hence the onus in on the therapist to adapt to and fit with the client, rather than the other way. De Shazer, in a seminal article, 'The Death of Resistance', described resistance as a redundant concept that could inadvertently increase the stuckness of therapy (de Shazer, 1984). He suggests that we see all client behaviours, including those traditionally labelled as 'resistant', as simply the client's 'unique way of cooperating'. Many models of therapy have moved away from the concept of resistance, for example cognitive-behavioural approaches, and seem to produce effective therapeutic outcomes without the concept of resistance (Lambert & Bergin, 1994).

In the early 1940's Carl Rogers developed what is known as *nondirective, or person-centred counselling* as a reaction against the directive approach of psychoanalysis. This model is based on the relationship between the client and therapist and believes that this relationship is the bases for human change (Rogers, 1951; Rogers, 1957; Rogers, 1986). The SFBT model differs in that it is directive in

the questions and focus of the therapeutic intervention. The SFBT model is centred on questions that lead the client's focuses towards a future life that is more satisfying to them. The relationship between client and therapist is not emphasised, and indeed downplayed. The SFBT model believes that the client should be made the expert of change, not the interaction between the client and therapist.

More recently there has been development of Cognitive-Behavioural approaches including Rational-Emotive Therapy (Ellis, 1962; Ellis & Dryden, 1987; Ellis & Grieger, 1977; Ellis & Grieger, 1986). The emphasis of this approach shifts away from feelings to the client's beliefs about events. It is thought that it is not the event that causes negative feelings for individuals but their belief about the event. This approach focuses on challenging irrational beliefs of individuals and stresses thinking, judging, deciding, analysing, and doing. The SFBT model differs from this approach in that the emphasise in not on the negative or irrational thought patterns of the client, but the times when the client is able to think, feel, or behave in a way that is useful to them.

As outlined in this section there have been many new and innovative models and therapeutic interventions in the past seventy years (Corey, 1991; Ellis & Dryden, 1987; Rogers, 1951). It is not possible to outline in detail that various models that have been developed. Yet it is possible to highlight the unique contribution of the SFBT model in its emphasis away from a problem past, may that be

behavioural, emotional, or cognitively to a preferred future. This commitment to the development of possible futures and client strengths as the core concepts of the model is distinctive to the model of SFBT.

Techniques of Solution Focused Brief Therapy

Problem-Free Talk

According to SFBT, the principal focus shift is from the client's problems towards possible solutions to these problems. This is highlighted by the concept of *problem-free talk* in an SFBT session. Problem-free talk is chitchat with the client about topics other than the presenting problem to gain a sense of the person as greater than their struggles. In many therapeutic settings there is a danger that therapists connect with the problem of the client rather than the client as a person. The idea of problem-free talk is that it gives the therapist the opportunity to connect with the client as a person and to begin to note their positive aspects that may miss through overly focusing on the problem. Interestingly, when clients see that therapists recognise that they are more than the sum of their problems, clients often feel freer to talk about what they want to change. They may even start to believe that change is possible.

It is the basis of the model to notice and highlight the client's strengths, skills, and resources. SFBT assumes that change for the client will come about as a result of their successful knowledge and application of their strengths, skills and resources. Therefore it is useful

to help the client identify these from the beginning of the therapeutic process. In the initial problem-free conversation with the client it is useful to be aware of and make a mental or written note of any skills, strengths and resources that the client brings up. The therapist can facilitate this process by asking the client (or asking themselves) questions such as:

- *What are the client's strengths and resources?*
- *What is it that the client does well?*

Constructive Listening

The importance of listening carefully to clients is perhaps the least disputed principle in counselling and therapy. This is best exemplified by the work of Carl Rogers who emphasised the basic human relationship between therapist and client as the crucible of change (Rogers, 1957; Rogers, 1986). Rogers argued that until the client feels understood and the therapist has the client's best interests at heart, little therapeutic change could take place. Rogers described in much detail the skills of what he called empathetic listening such as reflecting back, acknowledging, paraphrasing, and summarising. He talked about the essential attitudes of unconditional positive regard and acceptance, genuineness and congruence, and accurate empathic understanding which the therapist needs to communicate to the client in order to create a good therapeutic alliance.

SFBT also emphasises the importance of listening to clients and in many ways SFBT skills and techniques can be seen as an addition to the core Rogerian counselling skills and attitudes outlined above. However, SFBT argues that eliciting detailed information about the problem is not necessarily helpful in moving towards a solution. SFBT seeks to deal with this by introducing a different way of listening that is described as 'listening with a constructive ear' (Lipchik, 1988). Using this approach, rather than listening neutrally, the therapist is listening for the client's strengths, skills and resources and for what's right, not just for what's wrong.

This constructive listening approach builds on Rogers's three basic attitudes of unconditional positive regard, genuineness and empathic understanding, while adding one other – a sense of respectful curiosity towards the client. When therapists listen to clients they are interested in them as people; curious about their goals and what they want in their lives. Therapists are interested in finding out more about the strengths and resources already possessed by their clients that will help them to lead the lives they wish. This attitude of respectful curiosity towards clients is demonstrated in a fundamental approach common in all the techniques of SFBT - the art of asking constructive questions.

It is suggested that there are five kinds of questions in SFBT. The first are questions that elicit descriptions of the pre-session change, things the clients did that was helpful *before* attending therapy.

The second are *miracle questions* that help define the clients' goals. The third are questions whereby clients rate themselves in relation to their problem on a numerical scale. The fourth are questions that help to develop exceptions to the problem that the clients are trying to overcome. Finally, there are questions about how the clients are coping with the present situation (Friedman, 1993). The following will outline and develop these various techniques of questioning that define the solution focused model.

Pre-Session Change

SFBT is change focused: the aim is to help clients change towards their goals. Solution focused therapists are always looking for examples of change in clients' lives. By exploring how change occurs in a client's life therapists can begin to understand the patterns and mechanisms of change that are likely to occur again.

A very specific example of this is *pre-session change*. Steve de Shazer and his colleagues noticed that when clients were asked what changes had occurred between deciding to come to therapy and coming to the first session, over 60% reported positive changes – already things were changing for the better prior to therapy starting (McKeel, 1996). SFBT believes it is crucial to focus on these small positive changes as a way of building steps towards a solution. As these changes have occurred outside therapy, the client can take total responsibility for these changes. The positive changes, if highlighted,

may then become the basis upon which the client finds solutions to their problem or ways of coping with the situation that brought them to therapy. If discussed, these changes help the client to notice what they are already doing right and encourages them to continue these behaviours.

In support of the importance of pre-session change, research was conducted with clients who scheduled a first appointment and then did not show or cancelled the appointment. These clients were contacted and asked why they did not attend. More than a third of these clients reported they did not attend because of improvements that had already occurred (McKeel, 1996). Other research suggests that clients displaying pre-session change were four times as likely to finish therapy successfully (Beyebach, Morejon, Palenzuela, & Rodriguez-Arias, 1996).

Goal Setting

One of the key factors that distinguishes brief from long-term therapies is brief therapy's focus on goal setting. SFBT maintains that therapy can be brief if clear, focused and client-centred goals are negotiated from the outset. The quickest way to complete a journey is to begin with a clear idea of where you want to go, rather than focusing on where you have been or where you don't want to go. It is important to establish clients' goals for the therapy or the session in question early on. Some useful initial questions are:

- *What needs to happen so that this session will be useful to you today?*
- *What would be the most helpful thing to talk about today?*
- *How will your referrer/agency know today's session has been helpful to you?*
- *What is your best hope for this session?*
- *How can I be helpful?*

Goal setting questions establish a concrete goal, provide a way to measure the usefulness of the therapy for the client and help to build the expectation that change is going to happen (de Shazer et al., 1986). There are several guidelines to setting useful goals: 1) goals should be small, simple, and realistically achievable, and 2) the goals must be a positive replacement behaviour. For example, if a client wants to stop drinking, the therapist asks what the client would do instead of drinking. The client might reply that they would be able to hold down a job and have a better relationship with their family. It is much easier to have a client do something, than not doing something. The third guideline to setting useful goals is that the goals must be important to the client and generated by the client and not the therapist (Berg, 1991).

Research suggests that ideas and plans generated by clients themselves are more likely to be carried out and effect change (Duncan & Miller, 2000; Hubble, Duncan, & Miller, 1999). Other research suggests that the presence of clear goals doubles the

likelihood of successful outcomes of therapy (Beyebach, Morejon, Palenzuela, & Rodriguez-Arias, 1996).

In developing a goal with the client the therapist is creating a preferred future for the client. This is the creation of another possible way for the client to lead their life in the future. SFBT represents a shift from analysis of unwanted pasts to the building of detailed and empowering preferred futures. This is often a natural development of the client's goal for the session. To build a picture of the preferred future SFBT asks a number of questions that orient the client to thinking about when the problem is no longer present. These may include simple goal setting questions such as:

- *What needs to happen so that you know therapy has been useful to you?*
- *How will you know when things are good enough for you to finish therapy?*

However, setting goals with clients is by no means straightforward. Often, people's goals are unclear or muddled. They may be very clear about what they don't want, but unsure about what they do want. Indeed, de Shazer (de Shazer, 1991) described therapy as two people talking to each other and trying to find out what the hell one of them wants. The aim of the solution focused therapist is to help the client formulate *positive*, *clear*, *detailed* and *manageable* goals for the future which they have the resources to achieve (Berg, 1991). SFBT has devised a number of ways to help clients set goals that are

designed to meet these criteria. The most distinctive of these is the *miracle question.*

The Miracle Question

The miracle question is a key goal-setting question in SFBT. It can be posed simply as:

- *If the problem disappeared overnight, by magic, what would your next day be like*?

or more dramatically as:

- *Imagine that when you go home tonight a miracle takes place and the problem that brought you to therapy completely disappears. But of course being a miracle you did not know it has happened. What will be the first thing you notice the next day that will tell you it has happened?*

The key with the miracle question is to get as much rich detail as possible and thus follow it up with many questions:

- *What do you notice that is different?*
- *What do you see/feel/hear differently?*
- *What are other people saying/doing differently?*
- *If we were to follow you through a day with a video camera after the miracle had happened, what would we record?*

The effect of building clear descriptions of clients' goals can be quite dramatic. Clients who have been stuck in a problem saturated description of their life can begin to envision the possibility of a life

without the problem. This can be highly motivating and spur them into action. Equally, when preferred futures are richly described, clients can see examples of the goals already occurring in their life, or see small manageable steps which they can easily make. For example, if in a miracle question scenario, a client describes getting up early and going out for a walk, or talking pleasantly to his wife, these events are all within his reach to create the next day. The act of constructing a vision of the miracle acts as a catalyst for bringing it about (Kowalski, 1990).

To focus on examples of the goal already occurring, the following questions can be asked.

- *Which parts of the miracle do you think sometimes already happen in your life?*
- *When were you closest to the miracle happening?*
- *What would be the first sign that the miracle was happening?*

Scaling Questions

When a client sets a goal it can sometimes seem very far away, or too large to tackle. Scaling questions provide a way of breaking a goal down into small manageable steps which can be carried out in the short-term. Scales can also help clients to see the progress they have already made (pre-session change), and creatively focus them on the resources, skills and strengths which move them towards the solution. The standard example of a scaling question is as follows:

- *On a scale between one and ten, where ten is where you completely achieve your goal and one is the furthest away you have ever been, where would you place yourself today?*
- *On a scale between one and ten, where ten is the best and one is the worst things have been, where would you place yourself today?*

Depending on how the client responds, the therapist has a number of follow-up questions that elicit strengths, skills, resources, and ways of making small steps towards the goal. For example, if the client answered "four" to the scaling questions above the therapist could respond:

- *What makes you think you got that far?*
- *What things have you done already that convinces you that you are at four?*
- *What moved you from three to four?*

These questions elicit from the client the things they are already doing that have helped them to cope with or begin to overcome their problem. Other questions that might help the client focus on what they can do in the future are:

- *What do you think will move you one step further on?*
- *What would move you to five?*

Scaling questions can also be used to involve other significant people in the client's life. Even if the client is attending the therapy session on

their own the therapist can ask questions about the significant people in the client's life. This helps the therapist gain different perspectives of the client. Also the client might be able to have other people attribute strengths to them, where might feel uncomfortable for boosting if they recognize these characteristics themselves. For example,

- *If I were to ask your partner where you are between one and ten in achieving your goal, what would they say?*

If the client believes their partner would rate them slightly higher, you could ask:

- *What makes your partner more confident?*
- *Why do they think you have gone further?*

If the client believes their partner would score them lower:

- *What would it take to convince your partner that you are moving towards your goal?*

Both these questions are eliciting, once again, strengths, positives, and small steps that can help move towards a goal.

Scaling questions can assess self-esteem, self-confidence, investment in change, willingness to work hard to bring about change, and can evaluate progress (Berg, 1991). The idea of scaling can be applied to all types of questions, with the same assumptions. Scaling questions are intended to create a sense of movement and achievement.

When a client feels far away from their goal or that there are a large number of steps to be taken to get there, it can be quite useful to

ask a scaling question about their confidence to resolve the problem. This question can elicit new resources and strengths (e.g. beliefs and optimism). For example, *"On a scale between one and ten, how confident are you that you would be able to move to the next step towards what you what in your life?*". This question can develop within the client their level of belief in themselves. Depending on the client's answer, the therapist has the choice of the normal follow-up questions:

- *What makes you that confident?*
- *What will make you that little bit more confident?*
- *What do you know that makes you more confident than others?*
- *What will move you one step on?*

Even when a person feels far away from their goal and unconfident about getting there, a scaling question about their motivation can elicit inner strengths and resolve and also clarify if it really is their goal.

- *On a scale between one and ten, how much do you want to give up drinking?*
- *On a scale between one and ten, how willing are you to work to solve this problem?*
- *Who is most motivated to solve this problem? On the same scale, where would you put their motivation? What makes them more motivated?*

If the client rates himself or herself very low on a scale, for example at one or zero, there are still a number of solution focused approaches which can keep the session in solution talk:

- *It sounds pretty bad today. How are you coping?*
- *Have you always been at that point in the scale? Were there times when you were slightly further on? What was different about these other times?*
- *This is the lowest you have been; yet you are still coming along today believing something can be different, what gives you that hope?*
- *What is the smallest change that would need to happen to give you the smallest sign of hope?*

Scales can be used to "measure the client's own perceptions of the problem, can motivate and encourage change, and can help develop goals more clearly" (Friedman, 1993). However, when a client is feeling low the therapist should not 'force' the conversation into solution talk. Sometimes the therapist needs to simply hear and acknowledge the client's feelings. They need to be sensitive to the client's pace, and abandon for a time techniques and ideas of change, if that is what is helpful to the client (Nylund & Corsiglia, 1994).
This frequent use of scales helps to record a sense of movement in the therapeutic process. The client can begin to see progress in their problem and gain hope of the possibility of change. The scales that are used in the therapeutic process have historically been used to measure the outcomes of the model. In the early research into the outcomes of SFBT, scales were used to measure the client's perception of change and helpfulness of the therapeutic process. It is

the intention of the research presented in this paper to respect the historic protocol of past research into the effectiveness of SFBT, but also to provide a new approach on the data collected into the effectiveness of the model. This research project uses the format of scaling questions to gather data in relation to the client and therapists' perceptions as to what is happening within the therapeutic process and the perceived helpfulness of these interventions. The research also collects data on the effects of clients' coping resources on a standardised measure of coping resources. The combination of the use of a standardised measure and the use of scaling questions to elicit data is unique in the research into the effects of SFBT.

Exception Questions

At the heart of solution focused therapy is the belief that there are always exceptions to problems. In this sense problem patterns are never rigidly fixed through time and different situations. There are always times and situations when the problem occurs slightly less frequently or even not at all. Indeed the fact that a person is aware that there is a problem suggests that he or she is making a comparison to another time or situation when the problem did not exist. For example, a man who feels depressed only knows he feels this if he has a sense of other times when he was happier.

These exceptions are often forgotten, ignored or considered to be flukes. Solution focused therapy however, believes that it is

exceptions that deserve the closest attention in therapy. They signify examples of 'micro-solutions' already occurring within the clients' experience and ways in which clients have applied existing resources. They can be conceived of as chinks in the armour of the problem. If understood and explored they can be amplified and repeated, ultimately leading to the eventual dismantling of the problem. Exception questions can be asked in many ways:

- *Tell me about the times when* (the complaint) *does not occur, or occurs less often than at other times?*
- *When does your partner listen to you?*
- *Tell me about the days when you wake up more full of life?*
- *When are the times you manage to get everything done at work?*
- *At which times of the week are you most depressed?*

(Therapist actively listens to the client before asking)

- *So at other times of the week you feel a little less depressed?*
- *Tell me what you do then that is different?*
- *When are the times you have come* closest *to remaining calm when disciplining your child?*
- *When did you last wake up feeling good?*
- *When have you been about to go on a drinking binge but suddenly something happened and you stopped yourself?*
- *Are there times when you expect yourself to lose your temper but you remember something that calms you down?*

- *How do you achieve that?*
- *How do you explain to yourself why these times are different?*
- *What do you do differently then?*
- *Who else is involved that notices the difference? What do they say/do? What else?*
- *What else?*
- *What would you have to do/say for this to happen more often? What else would help this to happen?*

Coping Questions

Solution focused therapy believes in the competency of clients. The model believes that despite having problems clients still have access to a number of strengths and resources which allow them to survive and manage their lives. These strengths are often forgotten or not fully accessed, yet if they can be identified and emphasised they can provide a rich store of resources not only in maintaining the current situation but also in solving the problem. Coping questions are particularly useful for clients who are less optimistic about change, or who can't see exceptions and see the solution as being outside their control. The questions themselves bring to the client's attention that they are already doing something, maintaining the positives in their situation. The following are examples of Coping Questions:

- *How do you cope with the difficulties you are facing?*
- *What keeps you going?*

- *How do you manage on a day-to-day basis?*
- *Who is your greatest support in dealing with this problem? What do they do that is helpful?*
- *This problem feels so difficult at the moment yet you still managed to get here today. What got you here?*
- *Sometimes problems tend to get worse. What do you do that stops your problem worsening?*
- *How do you get through these periods?*
- *Who is your greatest support?*
- *How do they help?*
- *How did you manage to solve that problem in the past?*
- *Other people might have had more difficulty but you managed to survive and get here today, how did you manage to achieve that?*

Reflection Break

The process of SFBT can be conceived as a constructive feedback loop between therapist and client. The client presents their story and the therapist listens and reflects back to them, giving positive feedback and highlighting exceptions to the problem. What distinguishes SFBT from other therapies is that the therapist's feedback is always strengths-based: it is always focused on the client's resources and their own potential to solve their problem. The therapist essentially attempts to feed back to the client the best possible frame they have noticed or observed.

To facilitate the process of constructive evaluation and feedback, an important ritual that is incorporated into an SFBT session is that of the therapeutic break. This comes from the family therapy tradition (Boscolo, Cecchin, Hoffman, & Pann, 1987) where therapists often work in teams. The break allows the therapist the opportunity to reflect and think about the session and to consult colleagues if they are working in a team. Even when working alone, a five-minute break can have a number of therapeutic benefits for the client (Sharry, Madden, Darmody, Miller, & Duncan, in press). Historically, the solution focused team would develop homework tasks or *experiments* to assign to the client after the break (de Shazer & Berg, 1997).

De Shazer and his team (de Shazer et al., 1986) described the discussion during the break as: not talking about the complaint, things that the client is doing that is good for them, any exceptions to the

complaint pattern that have been raised, and what the team imagines the client will be like once the complaint is part of the past. The break is considered an important part of the model and is taken regardless of whether there is a reflecting team or not. When working individually, the therapist would still take the break to reflect on his or her own about the session and to consider the points mentioned above. The importance of the break in the model is reflected by de Shazer and Berg where they list it as one of the four things that needs to be happening in a session for it to be defined as Solution Focused Brief Therapy (de Shazer & Berg, 1997).

In more recent articles regarding SFBT, there has been a shift from the therapist giving feedback and tasks to the client, to the therapist encouraging the client to develop their own steps forward towards a solution. This allows the client's initiatives, ideas and plans to be evaluated prior to those of the therapist, making the client the expert on change (Sharry et al., in press).

Taking a break also gives the client time to reflect and think about the session. It punctuates the session, allowing specific time to plan or reflect on the key moments. How the break is introduced to the client is important. One possibility is:

Near the end of the session we take a five-minute break. This is to give you time to consider and reflect about what we have discussed; to pick out the important ideas that came up; or to make any decisions or plans. You might also like to think about whether this session has been

useful and how you would like us to be further involved. While you're reflecting I will consult with my team for their view and also consider about what we have discussed. If you would like to hear some of my ideas please ask me when I come back.

The emphasis is on the client thinking and reflecting and possibly planning. There is no assumption that therapy need continue. This in essence reflects a core assumption of Solution Focused Brief Therapy – that each session could be the last or that a small number of sessions could be enough to create change (Hoyt, 1998; Talmon, 1990).

After the Break

After the break there are two main parts to the discussion: 1) compliments and 2) suggestions (de Shazer et al., 1986). The break can heighten the client's expectation of a summary of the key observations of the therapist. Within SFBT it is best to give this feedback in the form of compliments - the therapist highlights one or two strengths they have noticed about the client and feeds them back (de Shazer et al., 1986). The process of giving positive feedback is most powerful when a quality initially thought of as a deficit is presented as a strength and possibly containing the seeds of a solution. For example, mothers are often pathologised as having over-protective or 'enmeshed' relationships with their children. This can be reframed as a mother demonstrating a desire for a very close

relationship with her children, or indicating her efforts to protect them. Equally, where a father is seen as overly-critical of his children this can be reframed as a reflection of his desire for them to achieve their potential or as an indication of his ability to see his children's capabilities. The therapist should also be optimistic and upbeat in his or her feedback, predicting and picking out examples of change. The aim is to have a sort of cheerleading or coaching effect, helping the client to adopt an optimistic view in his or her own life. Research indicates that the therapist and client's optimism or hopeful view is a key indicator of successful therapy (Miller et al., 1997). When presenting feedback to the client and predicting change, it is essential to be genuine. The feedback must be presented congruently and reflected in the therapist's body language and tone of voice.

Homework and Tasks

In addition to the tasks generated by the client and/or therapist, Berg (Berg, 1991; de Shazer, 1986) recommends a number of 'skeleton key' tasks which can apply readily in most situations. The most well known is the 'formula first task':

- *Between now and the next time we see you, keep track of what goes well in your life that you want to see happen again and again.*

Research collected on subsequent sessions from clients who were asked this question showed that 89% of clients reported

something worthwhile happened and 57% reported that the situation was better (McKeel, 1996). These observational tasks are designed to continue to focus the attention of the client towards exceptions rather than the problem (Kowalski, 1990).

Although the concept of tasks and experiments is a key concept in the solution focused model, the research shows that clients who either complied with or modified the tasks assigned, did not get better results than those who did not perform the assigned task (Beyebach et al., 1996). Therefore it is suggested not to check in to see if the task has been completed in following sessions. Rather, start with, "What has been better, even a little?"

Levels of Motivation

SFBT conceives of clients as having three different levels of motivation. These are not fixed labels, but rather categories which help describe a client's motivation to a certain goal at a given time or context. The first category of description is the *customer client.* A customer is the ideal client. They are motivated to change, see the problem as something to do with them (and thereby something they can change) and they are willing to carry out action plans and try new things. A customer welcomes doing tasks assigned by the therapist or developed by themselves.

The second level of motivation is the *complainant.* A complainant (this term is positively renamed as a 'browser' by Miller et

al., 1997) is someone who thinks there is a problem, is motivated to change it, but sees it as something beyond their control. Complainants believe change has to do with how other people are behaving and thinking. A mother bringing her teenage son to 'get therapy' due to his drug addiction, could be an example of a complainant. The complainant does not want to do anything different. The focus at this stage of motivation is on *noticing, reflecting* and *observing*

Thirdly, there is the *visitor* level of motivation. A visitor is someone who has come to therapy because they were sent or cajoled. They do not think that there is any problem or that anything needs to change – except perhaps the attitudes of those pressurising them to come. The drug-taking son in the above example could be a visitor. Visitors are not yet motivated to carry out any tasks. It is suggested that the therapist simply compliment visitors for coming and point out any other strengths the therapist has noticed.

The model of Solution Focused Brief Therapy is a relatively new therapeutic idea of how to create change in therapy, with the first article describing the origins of the model in 1974 and becoming more formalised in 1985 (de Shazer, 1974; de Shazer, 1985). Yet the ideas have had a great influence within the therapeutic profession, as mental health professional search for more creative, effective ways to work with clients. Although the model is constantly in development, data has been continually collected from the centres around the world that

practice using these types of interventions (Sharry, Madden, & Darmody, 1998).

Existing Research

The research comparing short-term models of therapy and longer-term models of therapy is not specific to the model of Solution Focused Brief Therapy. It is also important to draw a distinction between brief therapy defined by time and brief therapy defined by the number of sessions attended (de Shazer & Kral, 1986). In de Shazer's 1986 article he argues that brief therapy should be defined as a way of solving human problems instead of the number of sessions or time frame they are applied in. He believes that brief therapy is defined as 'brief', not by the number of sessions the client attends but by the assumptions the therapist brings to the counselling intervention. In a brief therapy model a therapist may only see a client for three sessions, but these sessions could be spread over a year. For most however, the term brief therapy has been defined as therapy that was concluded in fewer than 25 sessions (Talmon, 1990).

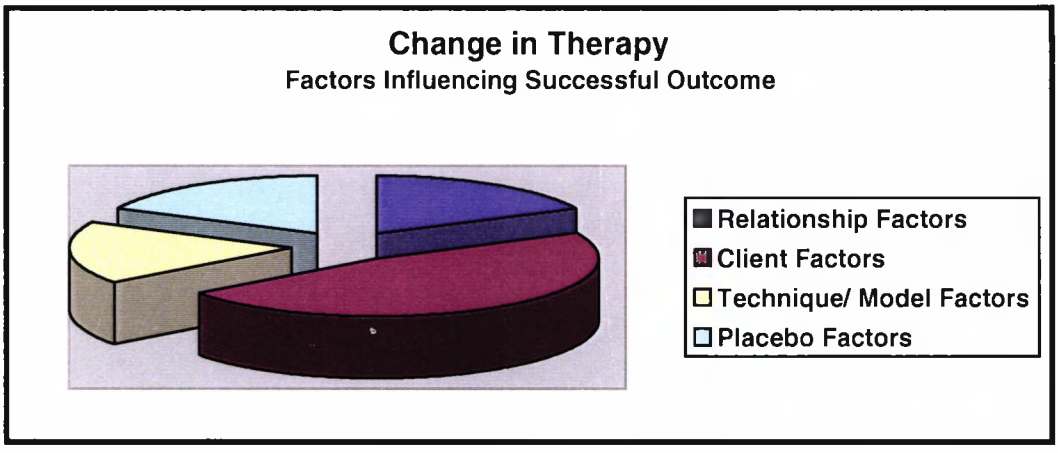
The reality is that short-term models of intervention are in fact as effective as longer-term models of therapy (Koss, 1994; McKeel, 1996) (Lambert & Bergin, 1994). The research also shows that brief models of therapy do not reduce the number of sessions that clients attend. The median length of *all* therapy, regardless of the model being applied, ranges from four to eight sessions, clustering around six

(Garfield & Bergin, 1994; Miller, 1994). The vast majority of clients see a counsellor for six sessions or less with 40% of clients stopping short of attending six sessions (McKeel, 1996). Other research presents that 50% of clients terminated by the fifth session, while 80% had completed by the tenth session (McKeel, 1996). The Brief Family Therapy Centre, the founders of Solution Focused Brief Therapy, claims to have an average of 4.6 and 4.7 sessions (Metcalf & Thomas, 1994; Miller, 1994). However, this average number of sessions is not that impressive when compared to the Health Care Statistic, which is 4.6 sessions (Miller, 1994).

Not only does the research point out that brief therapy is effective and that most therapeutic interventions are under eight sessions, it also highlights that it might not be effective to continue with clients in the long term. It is suggested that clients' presenting problems continue to improve until the eighth session and then the treatment gains become much slower (Howard, Kopta, Krause, & Orlinsky, 1986) (McKeel, 1996). Another research piece highlighted that 75% of clients who did find benefit in therapy did so in the first six months of contact (Howard et al., 1986). McKeel (1996) also notes that most clients believe that therapy will be short-term from the outset. When asked at the onset of counselling, 70% of clients stated that they expected to attend the therapy for ten or fewer sessions. Many believe that the therapeutic process is speeded up by the client's awareness of

a time limit or the expectation by the therapist that the intervention will be short (McKeel, 1996).

Regardless of the model employed in therapy it has been a long accepted fact that therapy helps. Lambert (Lambert & Bergin, 1994) claims that 66% of clients who received therapy (regardless of the model) showed improvement, while only 34% of those who did not receive therapy showed improvement. The model of therapeutic intervention employed to elicit these changes is believed to be less important than previously thought. The data from Lambert (Lambert, 1992) shows that 40% of factors that influence successful outcomes in therapy are put down to the client, these are the extra therapeutic variables that are part of the client's life and their environment that contribute to change regardless of the client's participation in therapy. Where 30% of the change factor is related to the relationship between client and therapist, another 15% is attributed to the placebo effect, the client's hope that the things that they bring to therapy will improve. Therefore, only 15% of change is credited to the techniques or model that the therapist employs to influence change (Lambert, 1992).



*Data from Lambert, 1992.

Although the research continues to point out that it is not necessarily the model of therapy that has the greatest impact on change, professionals continue to argue about the validity of the various therapeutic interventions and demand outcome studies on the a range of models employed in therapy. Solution Focused Brief Therapy is a relatively new model of working (de Shazer & Berg, 1988) (de Shazer, 1986). Therefore the work of the team that originated the ideas in Milwaukee, has focused on the clinical development of the work. De Shazer and Berg (de Shazer & Berg, 1997) describe the development of the model as deductive; first trying something, then seeing if it works and then trying to describe it. The approach can be described as experimental and research oriented from the beginning. Yet the research into the model was being used to develop the ideas in relation to clinical practice, instead of focusing on outcomes of the model.

Brief Family Therapy Centre Research

Early research into the model of Solution Focused Brief Therapy was collected in the Brief Family Therapy Centre (BFTC) in Milwaukee. In the first outcome study published in Solution Focused Brief Therapy de Shazer (de Shazer, 1985) reported findings in relation to the intervention of the *formula first session task*. The client was asked to:

- *Notice between now and the next session the things in your life that are helpful*

De Shazer reports that upon follow-up of twenty-eight cases, twenty-three reported an improvement of 82% and twenty-five of the cases reported having solved other problems since the therapy. He reports that clients attended an average of five sessions. This early collection of data for research set the standard that clients' perception of improvement and change were used as the base measure in solution focused data. Although this reflects that ethos of the model, making the client the expert, if falls short of rigorous research methodology.

In 1986, de Shazer, Berg, Lipchick, Nunnally, Molnar, Gingerich, and Weiner-Davis (de Shazer et al., 1986) published a paper outlining the development of the model and the evaluation of their services from 1978 to 1983 with over 1,600 cases. They had a sample of 25% of these cases and found that 72% of these clients met their goals for attending therapy or felt that there was significant

improvement made towards these goals. This data was collected by telephoning clients after they had finished therapy and questioning them in relation to whether they had met their goals and whether they had to access other services in relation to the problem(s) that had brought them to the therapy. The Milwaukee team rated cases as having been successful if the client said they had reached their goal or were significantly closer to this goal and that no one in the household accessed treatment in relation to the presenting problem. This research conducted at the BFTC continued the precedent for the collection for data for several other research projects.

In another publication from de Shazer and the team working in the Brief Family Therapy Centre in Milwaukee (de Shazer, 1991). De Shazer reports that twenty-nine cases were followed up after finishing therapy. He reports that twenty-three of the cases (80%) reported that they had either resolved their original difficulty or made significant progress towards resolving it. At eighteen months after finishing therapy the success rate was 86% and 67% of cases reported other improvements as well. De Shazer reports that the average number of sessions attended for this report was 4.6, and that those subjects that attended four sessions or more did better.

Another research project published by DeJong and Hopwood (DeJong & Hopwood, 1996) outlines treatment conducted at the Brief Family Therapy Centre in Milwaukee from 1992 to 1993. In this report they asked clients to rate themselves on a scale in relation to their

progress in therapy. The data that they collected from clients at the last session showed that 26% of clients rated themselves as having made no progress, whereas 49% rated themselves as having made moderate progress and 25% rated themselves as having made significant progress. DeJong and Hopwood followed up these clients seven to nine months after the final therapy session and they had responses from 50% of these clients. Of this 50%, 23% of the clients rated that they still had made no progress, 32% rated that they had made significant progress and 45% stated that they had reached their goal for therapy. The researchers also reported that this success rate did not have a correlation with the client's age, employment status, gender, or race. The researchers interpret this as outcomes of therapy were not determined by the variables of the clients. The team found that female and male therapists worked equally effectively with either female or male clients and that the client-therapist racial mix had no effect on outcome. DeJong and Hopwood imply that the model was consistently successful regardless of presenting problem, with the exception of panic attacks and health problems. In their conclusion the researchers state that over three quarters of the clients attending the centre fully met their goals or made significant progress towards their goals and that this level of effectiveness occurred over an average of three sessions.

Another study conducted by McKeel (McKeel, 1996) carried out at the Brief Family Therapy Centre in Milwaukee showed that 65.6% of

clients reported accomplishing their treatment goals and 14.7% of clients stated they made significant improvement. McKeel showed that 91% of clients who attended four or more sessions achieved their goals, whereas only 69% of clients reported this success after having attended three or fewer sessions. McKeel also suggests that after eight sessions there is little progress made towards the goals. In this study he proposes that the number of sessions attended is significant to the outcome of therapy and that it is most beneficial for clients to attend between four to eight sessions (McKeel, 1996).

These early research projects at the Brief Family Therapy Centre (BFTC) set a precedent for future investigation in relation to the collection of data of Solution Focused Brief Therapy. The team at the BFTC felt that the client should define the outcome of the therapy as useful. Therefore the majority of the early research methodology used the data collection of client self-report as a base measure. This methodology was consistent with the ethos of the model of trusting the client and having the client as the expert on their own life. However, this method of data collection fell short of the standard protocol of rigorous scientific methodology. In reviewing research where the client makes self reports of progress it is important to interpret these results with caution. There is a strong tendency for people to report positive change to a greater degree when making self reports. This tendency towards positive reporting may be to please the therapist for the time and attention that was given to the client, although real change might

not have taken place (McLeod, 1994). Nevertheless this practice continued and is reflected in the research presented in the remainder of this section.

Family Therapy

Solution Focused Brief Therapy was developed in a centre that worked primarily with families. Therefore it is understandable that the model would develop in the couple and family therapeutic profession. Much of the research that has been carried out using the solution focused model over the past fifteen years has been in the family, child, and parenting context.

Using the model with families, Lee published a follow-up study on family therapy (Lee, 1997). He followed up fifty-nine families six months after they finished therapy using independent assessors. The independent assessors telephoned the clients to ask questions about the clients' perception of the completion of their goals. Lee reported a 64.9% improvement after an average of 5.5 sessions. Lee also stated that of this 64.9%, 54.4% of the subjects stated that their goals were achieved and the remaining 10.5% reported that part of their goals were achieved (Lee, 1997).

Another outcome study on family therapy using Solution Focused Brief Therapy is from a team in Salamanca University's Family Therapy Centre (Beyebach et al., 1999). This team reviewed eighty-three cases that presented to the centre. The cases were

followed up by telephone one year or more after completion of therapy. The Salamanca team collected data in the same way as the team from the BFTC in Milwaukee. The Salamanca team reported an 82% satisfaction rating that did not differ between trainee and expert therapist, with an average of 4.7 sessions. Both Lee (1997) and Beyebach's (1999) results need to be interpreted with caution due to the self reporting nature of the data collection.

Couples Therapy

Research published by Zimmerman, Prest, and Wetzel (Zimmerman, Prest, & Wetzel, 1997) on couple therapy groups suggested that the solution focused model is helpful with this type of treatment. The researchers administered the Dyadic Adjustment Scale and the Marital Status Inventory to subjects who were attending a solution focused couple therapy group. The treatment group's scores improved significantly during the period they were involved in the therapy group. This research projects moves away from self reporting to the use of a standardised instrument, Dyadic Adjustment Scale that gives the research more strength. However, there was no control group used in this research, therefore making interpretation difficult as to the nature of the improvement.

General Counselling Practice

In Spain, research by Fontecilla, Ramos, and Rodriguez (Fontecilla, Ramos, & Rodriguez, 1993) used 250 clients treated with Solution Focused Brief Therapy. Fontecilla found that at termination 80% of the clients that continued beyond the first session were rated as successful cases by independent judges. The average number of sessions was five. Another research project conducted in Spain at the Universidad Pontificia de Salamanca, Beyebach and Morejon (in preparation) reports that a follow-up study conducted on eighty-five cases treated at the University produced similar results. This was measured by having independent judges rate tape-recordings of first and last sessions and at follow-up the clients answered a questionnaire by telephone. Between one and four years after the termination of therapy, 100% of clients who answered the telephone questionnaire said they felt satisfied with therapy. Ninety percent of the clients found therapy useful, and 82% said they had overcome their problem. Only 11% of the clients sought help from another mental health professional after their solution focused therapy. The average number of sessions in this research was 4.6. The authors concluded that excluding drop-out cases, 74% of the cases were considered successful at termination and the success rate at follow-up was 76%. There were no differences found between the success rates of expert therapists and trainees. The authors also reported that personal complaints (anxiety, mood disorder, addiction) had better outcomes at termination than relational

complaints (problems with children, spouses, family). Although these research projects include the use of independent judges to review tapes at termination, the main measures of improvement is self reporting by clients. Therefore these results need to be interpreted with caution.

In a general counselling context Lambert, Okishi, Finch, & Johnson (1998) report on their research findings that involved using the Outcome Questionnaire (OQ-45). This research project was developed after the development of the OQ-45 in 1994. This is a 45-item checklist using three domains: symptom distress, interpersonal relations, and social role. The more recent outcome publications of Solution Focused Brief Therapy have moved to using a more standardised instrument of measure. Lambert and Okishi used twenty-seven consecutive patients presenting at a private practice. The subjects, whose ages ranged from twenty-two to forty-five, had a wide variety of presenting problems. Fourteen of the subjects were male and thirteen were female. The number of sessions attended ranged between two-seven sessions. At the beginning of therapy, 82% of the patient's scores on the OQ were in the dysfunctional range. When the therapy was completed 46% of those who were considered dysfunctional were considered recovered and an additional 14% were considered "improved". Lambert and Okishi also reported that student therapists needed three times the average number of sessions in order to reach the final outcome attained by practised therapists. Although

this publication uses a standardised measure in the collection of data (OQ45), there are no control groups to compare and contrast results. Therefore, these results should be interpreted with caution.

The research presented in relation to outcome studies conducted on family, couple, and individual counselling interventions seems to support the usefulness of the model of Solution Focused Brief Therapy as an effective treatment in these contexts. The research protocol has shifted from a self-reporting of clients to define successful cases to more concrete measure of improvement, for example the OQ-45.

The model's flexibility lends itself to being applied to many different contexts and presenting problems. The creativeness and flexibility of the model allows it to be used with children and adolescents to help them develop their own goals and agendas within the therapeutic context.

Solution Focused Research with Children and Adolescents

Due to the model's wide application to children and adolescents there are several research projects exploring the usefulness of the solution focused intervention within these contexts, both with in mental health settings and schools.

In the research reported by Wheeler (Wheeler, 1995) from a child mental health setting, there seems to be significant difference for the treatment groups using Solution Focused Brief Therapy

interventions. Wheeler traced thirty-four cases that were treated using the solution focused model and thirty-nine cases that were treated in the routine referral procedure. He reports that 68% (n=23) of the treatment group were satisfied as opposed to 44% (n=17) of the control group. He also points out that of the treatment group, only 12% were referred on to other clinical resources; whereas 31% of cases in the control group were referred. Wheeler reported that: 1) since using the Solution Focused Brief Therapy model, that percentage of cases ending in withdrawal with outcomes unknown is reduced from 26% to 22%; 2) that the percentage of cases requiring transfer to other resources has reduced from 31% to 11% and that 3) the percentage of successful outcomes was raised from 43% to 67%. This report leads the reader to believe that the use of the solution focused model increases satisfaction while decreasing the use of multi-resources. This would lead to a cost savings within a clinic. This research uses both the usage rates of the service and a control group to develop the usefulness of the model, although it uses self report as a measure of success as rated by the client.

School Setting

There are several publications supporting the use of the solution focused model within the school setting both for proactive and reactive support for children and adolescents.

In a pilot study of three cases, Franklin, Corcoran, Nowicki, and Streeter (Franklin, J., Nowicki, & Streeter, 1997) used self-anchored scales to measure outcomes in solution focused therapy. Franklin and others went on to investigate the effectiveness of using solution focused therapy with children in a school setting (Franklin, Biever, Moore, Clemons, & Scamardo, 1998). The research looked at nineteen cases using a baseline of objective measures. After an average of seven sessions they report an improvement in all cases and that four out of five were better at a one-month follow-up.

In another research project conducted in a school setting in the US, Littrell, Malia, and Vanderwood (Littrell, Malia, & Vanderwood, 1995) looked at single-session counselling in a high school. They divided sixty-one students into three groups for single session therapy. Nineteen subjects were placed in a problem focused and task-assigning group, twenty subjects were placed in a problem focused group, and the remaining twenty-two subjects were placed in a solution focused and task group. The authors of the research reported that there was a 69% improvement rate at a six-week follow-up for all groups, but claim that the sessions were shorter in the solution focused and task group.

Morrison, Olivos, Dominguez, Gomez, and Lena (Morrison, Olivos, Dominguez, Gomez, & Lena, 1993) also reported on using the solution focused model in an elementary school setting. The model was used as an intervention with thirty students who had school

problems, six of which had special educational needs. The subjects attended between one and seven sessions of a solution focused intervention. The authors of the study reported finding that twenty-three of the subjects improved, but five relapsed.

The most recent study conducted in a school setting by Thompson and Littrell (Thompson & Littrell, 2000) reported on the use of the solution focused model with students who had learning disabilities. The authors looked at twelve students who attended for two sessions of Solution Focused Brief Therapy. The subjects were followed-up two weeks later and the authors reported that ten (83%) of the subjects achieved 100% of the goals they defined in the first session.

Perez (Perez & Grande, 1991) reported on another research project which involved children as subjects. This study followed up ninety-seven cases that attended for family therapy. Of these cases, 25% were children who attended for an average of five sessions. At the end of therapy Perez reported a 71% improvement in these cases. Perez stated that 81 of the subjects were traced in a telephone follow-up conducted an average of nineteen months after subjects finished therapy. Of these, 12% reported relapse and 38% reported that other problems had improved since the counselling intervention. Perez also made the observation that there were more drop-outs if the problem was long-standing.

A research project in relation to adolescents in a residential setting reports that after residential staff training, the adolescents were involved in 66% fewer incidents and used less medication than the control group (Triantafillou, 1997). This finding was reported sixteen weeks after the training intervention.

The preceding research supports the use of the solution focused model within the context of working with children and adolescents. The research highlights the versatility of uses, from proactive groups (Littrell et al., 1995), mental health agencies (Wheeler, 1995), children with special needs (Morrison et al., 1993; Thompson & Littrell, 2000), and adolescents in residential care (Triantafillou, 1997). The majority of these publications use self reporting as their baseline measure, yet some use other factors in additional to determine successful outcomes. For example Wheeler (1995) used the usage of the service and the need to refer on to other services as an indication of change, where Triantafillou (1997) used the rate of negative incidents and medication that the subjects engaged in as a measure of change. It is difficult to compare and contrast these various publications due to the differing types of interventions applied in each publication and the various types of methodology in the collection of data.

Parenting

In addition to the support of children the SFBT model is often used in relation to parent training groups to help parents cope with the

demands of parenting (Sharry, 1997; Sharry, 1998a; Sharry, 1998b; Sharry, Connolly, & Fitzpatrick, 1995; Sharry & Fitzpatrick, 1997; Zimmerman, Jacobsen, MacIntyre, & Watson, 1996). One research project that reflects this reported that with thirty subjects, where eighteen were provided with a six-session solution focused parenting group and twelve were part of the control group, the treatment group showed improvement on the Parenting Skills Inventory, but there was no change on the Family Strengths Assessment (Zimmerman et al., 1996).

A more recent publication relating to the use of solution focused work in parenting groups evaluates the Parents Plus Programme (PPP) (Sharry & Fitzpatrick, 1997). The Parents Plus Programme is a support group developed for parents of children attending a child and family psychiatric service. The programme was developed using the ideas of the solution focused model of intervention to develop the client's own coping resources within a group context. In a comparative outcome study involving forty parents whose children had disruptive behaviour disorders there was significant improvement of the treatment group compared to the control group. With respect to clinical significance, compared with controls, by the end of the programme twice as many parents who participated in the PPP reported that their children had moved from the clinical to the non-clinical range on the total problem scale of the Strengths and Difficulties Questionnaire (SDQ) and the externalising scale of the Child Behaviour Checklist

(CBL) and that they maintained these changes at a five month follow-up (Behan, Fitzpatrick, Sharry, Carr, & Waldron, 2000).

These findings verify the use of Solution Focused Brief Therapy not only in the use of individual therapy, but that the model can be applied to working with groups. Although Behan's (2000) research uses standardizes measure to collect data and has a control group to compare results it is difficult to compare this result with other interventions of solution focused clinical work. The Parents Plus Programme is a specific intervention that uses ideas from the solution focused model, yet interpreting these results to the wider usage of solution focused intervention should be done with caution. The change stated in the publication may be contributed to the positive effects of the group, instead of the model of intervention.

Group Work

In their 1996 publication, LaFontain and Garner (LaFontain & Garner, 1996) explored implementing the solution focused model with counselling groups. They used twenty-seven solution focused counsellors working with 176 students in the treatment group. The control group consisted of thirty counsellors and 135 students. They reported that the experimental group of students did better on three of the eight measures they collected and that 81% had achieved their goal. There were no results for the control group. The authors also reported that there was less exhaustion and depersonalisation of the

solution focused counsellors at a one-year follow-up. The lack of results from the control group makes it difficult to appropriately interpret these results.

Psychiatric Settings

The psychiatric setting can provide some of the most challenging work for the mental health professional. These are the cases that other professionals and agencies are perceived to have failed with and they are passed down through the system to "last-stop" psychiatric intervention. The solution focused model moves away from labelling clients as psychiatric and believes in looking at the person, not their diagnosis. These shifts in thinking allow the therapist to engage with the client as a person hoping to overcome their difficultly and begin to live a life that is meaningful to them. The success of this approach is supported by the research conducted in these types of therapeutic settings.

In 1993 Wolfgang Burr published his results of Solution Focused Brief Therapy at a child and teenage psychiatric practice (Burr, 1993). The child and teenage psychiatric clinic carried out a similar research project as the one in Milwaukee in 1986. The difference was that Burr used a self-rated questionnaire instead of telephone contact as follow-up. He had a 64% response rate to the questionnaires. Burr reports that 77% of cases said the problem had improved, whereas only 7% of cases stated that the problem had remained the same. In this study,

82% of the subjects reported that they had not had new treatment and felt that no new intervention was needed. The clients in Burr's study attended an average of four appointments. These results are similar to de Shazer's team's 1986 publication (de Shazer et al., 1986). Burr goes on to question if a team of therapists is needed to elicit these types of results. He suggests that the assumptions of the model and not the team of therapists is the key factor. His suggestions conclude that individual therapists could achieve the same results as therapists working in a team.

In 1994 Macdonald published his results from the context of adult mental health over a three-year period (Macdonald, 1994). One year after their last session all clients received a postal questionnaire asking: 1) Is the problem solved? 2) Were your goals for therapy achieved? 3) Have other problems been solved at the same time? 4) Have new problems appeared? 5) Has further involvement with mental health professionals been necessary? In the study Macdonald reports a good outcome for 70% of the cases. In this research he goes on to outline that the clients whom the researchers expected to improve the most did not differ in result from the main sample. Macdonald proposes these findings suggest that brief therapy is helpful to patients from all social classes in contrast to most other forms of psychotherapy, which tends to favour the higher social classes and those of a higher educational level (Macdonald, 1994).

In a 1997 follow-up piece of research that looked at the next three-year period within the same agency, Macdonald (1997) used the client's own feedback upon follow-up of the case but also established feedback from the client's general practitioner to establish if the therapy had been successful (Macdonald, 1997). Over the three-year period, thirty-nine cases were monitored. Of these cases, 64% were rated by both the client and general practitioner as having had good outcomes to therapy. These results were seen to support de Shazer's 1986 research (with a 72% success rate), Burr's 1993 research (with a 62% success rate), Macdonald's 1994 research (with a 70% success rate), and McKeel's 1996 research (with a 91% success rate). Although these are healthy improvement rates they should be interpreted with caution. Burr (1993) and Macdonald's (1994) research relies on self report to determine significant change. Although Macdonald's (1997) more recent publication uses the objective check of the general practitioner to reinforce the subject's view of improvement.

Moving on from traditional solution focused data collection, Eakes, Walsh, Markowski, Cain, and Swanson (Eakes, Walsh, Markowski, Cain, & Swanson, 1997) published the findings of their work using solution focused family therapy with sufferers of chronic schizophrenia. A control group was treated using traditional outpatient therapy and a treatment group was treated using Solution Focused Brief Therapy with the client and their family. The groups were given the Family Environment Scale before the therapy began and after the

therapy had been completed. The authors of the study reported that there were significantly improved differences in expressiveness, active-recreational orientation, moral-religious emphasis and family incongruence for the group treated with the solution focused model of therapy. This publication begins to address the short comings of previous research presented by providing a controlled study using standardised measures.

Another research project that moved away from the original protocol of client perception of outcome was a 1996 publication by Johnson & Shaha which researched the use of Solution Focused Brief Therapy at an adult outpatient treatment centre (Johnson & Shaha, 1996). For this research they used the standardised testing instrument the Outcome Questionnaire (OQ-45) (Lambert, 1994). Johnson and Shaha tracked thirty-eight cases at the treatment centre and gave the OQ-45 at every visit and a ten-item satisfaction measure. They reported that by the sixth session the complaints of all thirty-eight clients were well on their way to resolution. This project demonstrates the shift in research from the use of client perception only to the use of more standardised measures like the OQ-45 (Johnson, 1996).

Continuing the use of standardised instruments, Vaughn, Young, Webster, and Thomas (Vaughn, Young, Webster, & Thomas, 1996b) reported on an outcome study conducted at an inpatient psychiatric hospital. The research was conducted in 1992 with fifty-one patients who were put into two groups matched for age, sex, and

diagnosis. The Global Assessment of Functioning (GAF) was administered at admission and at discharge. The control group was treated in the regular treatment protocol of the psychiatric hospital. The treatment group was given immediate solution focused crisis intervention. The result of this treatment was that upon discharge the treatment and control groups' Global Assessment of Functioning (GAF) was not significantly different. Yet the treatment group's average length of stay in the hospital had substantially decreased. On average, 14% of patients from the control group left the hospital within three days of admission, whereas 40% of patients from the treatment-group left the hospital within three days of admission. Also, 40% of the control group left the hospital within ten days of admission, whereas 90% of the treatment group left the hospital within the same time period. There is a significant difference between the groups, considering that the Global Assessment of Functioning was not notably diverse and that there was no higher re-admission rate between the two groups. Patients also gave a higher satisfaction rating to the solution focused treatment intervention. The authors reported that after implementation of the programme the average cost for the service decreased from $9,095 per patient staying on average 20.2 days, to $2,961 per patient with the average length of stay decreasing to 6.6 days with the same recidivism rate. The researchers compare this with the current United States national average stay in a psychiatric facility of 17.8 days, and felt that the solution focused intervention was a key

factor in reducing the average by 11.6 days. The solution focused treatment programme made significant difference to length of stay, cost of service, and client morale (owing to staying as an inpatient for a shorter period of time) (Vaughn et al., 1996b). Vaughn's (1996) research begins to address the need for outcome studies to be both controlled and standardised in the collection of data.

The six studies discussed above highlight the effectiveness of the solution focused model in the difficult treatment of psychiatric complaints. Some of the research that was conducted followed the original research protocol of self-assessment of successful outcomes (Burr, 1993; Macdonald, 1994; Macdonald, 1997) while others used the more standardised instruments like the OQ-45 (Johnson & Shaha, 1996), the Family Environmental Scale (Eakes et al., 1997), and the Global Assessment of Functioning and length of stay in hospital (Vaughn et al., 1996b). Regardless of the method of data collection, all the research presented shows a significant increase in positive outcomes of the treatment groups using the model of Solution Focused Brief Therapy.

Orthopaedic Rehabilitation

The wide application of the SFBT model continues to be demonstrated by Cockburn's 1997 publication (Cockburn, Thomas, & Cockburn, 1997), an outcome study that was conducted in an orthopaedic rehabilitation work hardening program. This type of

programme is designed to assist individuals who have been injured at work or have been too ill to return to work. This is not a traditional context for therapy in a conventional sense, yet it shows the usefulness of having positive, goal-focused conversations with individuals. The research looks at a control group of twenty-three patients and a treatment group of twenty-five patients. The treatment group was given six sessions of Solution Focused Brief Therapy as part of their rehabilitation while the control group received the regular rehabilitation programme. The results were that 68% of the treatment group were back to work within seven days opposed to only 4% of the control group. This highlights the strength of goal-focused conversation being used to help individuals move towards a productive future, as defined by them, although this publications result are hard to apply to other therapeutic settings.

Multi-Cultural Populations

Another publication that highlights the diversity of the SFBT model is one that looks at counselling with a Hispanic-American population (Curz & Littrell, 1998). This study looked at sixteen cases that were given two sessions each and followed up two weeks after the completion of their therapy session. The publication reports that ten subjects achieved 54.7% of their goal as had been set out in the first session. The results of this publication can only be applied to the type of intervention that is mentioned in the research, two sessions followed

up two weeks later. Therefore, the wider interpretation of this publication is difficult to apply.

Prison/Mandated Clients

Another population that has been studied using the solution focused model is made up of subjects in prison or persons mandated to attend therapy owing to criminal activity. Lindforss and Magnusson (Lindforss & Magnusson, 1997) reported on their work using the solution focused model of therapy in a Swedish prison setting. A treatment group were given sessions of therapy using the solution focused model. A control group was handled in the routine manner. The authors reported that twelve months after release from prison 47% of the treatment group did not re-offend, whereas only 24% of the control group did not re-offend. After sixteen months, 40% of the treatment group had not re-offended, whereas only 14% of the control group did not re-offend. The authors also stated that twice as many subjects in the control group relapsed into a drug offence and that three subjects from the control group had died since being released from prison, whereas no subjects from the treatment group had died. Lindforss and Magnusson also refer to a 1992 study conducted in the same manner where twelve months after release 33% of the treatment group was crime-free, where only 10% of the control group is reported to have remained crime-free. Lindforss and Magnusson's report suggests that the control group cost the Swedish government 2.7

million crowns more than the treatment group, translating into a savings of 322,195 euros.

An innovative project by Sebord and Ukin concerns a 7-year therapeutic group project involving men convicted of physically abusing their partners (Sebord & Ukin, 1997). The participants had the choice between compulsory attendance of the group or a prison sentence. After attending the group re-offending rates among the participants were significantly lower that those of offenders allocated to more traditional therapeutic approaches. Sebord & Ukin claim a re-offending rate of 17% as opposed to a rate of 40-60% reported by other treatment programmes.

In another publication on domestic violence offenders, Lee (Lee, Greene, Uken, Sebold, & Rheinscheld, 1997) investigates two studies that used Solution Focused Brief Therapy. In one study he reports that 117 clients were treated with a standard six sessions of therapy. Of the 88.7% that completed that treatment model of six sessions, only six subjects re-offended. Lee also reviews a study between 1994 and 1996 where only 3% of the subjects re-offended. In a more recent paper Lee reports on a 6-year follow-up study where only 17% of the subjects re-offended (Lee, Greene, Uken, Sebold, & Rheinsheld, Unpublished).

Tohn & Oshlag (Tohn & Oshlag, 1996) similarly report a lower dropout rate and a higher level of client satisfaction rating when using the Solution Focused Brief Therapy model with mandated clients.

The research presented above gives a clear indication that the model of Solution Focused Brief Therapy seems to have a significant impact on mandated clients who attend for solution focused intervention, both within the prison system and outside, specifically Lindforss (1997) and Sebord's (1997) study, which used comparative groups and reoffending rates to determine the usefulness of solution focused interventions. Although these research publications are promising in their reported level of change, it is difficult to determine the factors that contribute to change as the interventions described above vary widely.

Substance Abuse

The presenting problem of substance abuse, both of alcohol and drugs, is an important aspect for mental health professionals involved in clinical work. Helping people move away from using substances to coping with their life difficulties is a large part of professional work.

There have been numerous publications on work done with substance abusers using the solution focused model (Berg & Hopwood, 1992; Berg & Miller, 1992; Isebaert & de Shazer, unpublished; Miller & Berg, 1995). The solution focused model moves away from the traditional twelve step programmes designed by Alcoholics Anonymous (AA) and into working collaboratively with clients on finding ways to control, reduce, or abstain from alcohol, whichever of these options the client feels is right for them (Miller & Berg, 1995).

Research in the area of substance abuse includes Parslow's 1993 follow-up study of solution focused work in a drug dependency unit in London, UK. This was a small study involving eleven clients. Of the eleven subjects who participated, ten of these reported that their complaint was better upon follow-up using self-reporting data collection. The average number of sessions in this study was 2.33, with all clients completing therapy in fewer than six sessions (Parslow, 1993).

More recent research that is currently under review for publication is Isebaert and de Shazer's study into the treatment of alcohol problems using the Bruges model of therapy, which is a development of the Solution Focused Brief Therapy model. This research was conducted in an inpatient programme for alcohol abuse. In this innovative treatment programme, when patients are first admitted to the unit they are treated for detoxification and as soon as possible psychiatric nurses trained in the model of Solution Focused Brief Therapy provide the patient with information on alcohol addiction. The nurses then help the patient and family decide what treatment programme the patient should enter: Abstinence (Ab) or Controlled Drinking (CD). Roughly equal numbers of patients choose each group. The patients are allowed to change groups at any point they feel is appropriate. In both groups the emphasis is on exceptions as defined by the Solution Focused Brief Therapy model. Once the detoxification and educational programme is finished, the patient can choose to 1)

continue with hospitalisation, 2) attend a day hospital, 3) attend an outpatient programme, 4) be referred to another programme or 5) be fully discharged. If the patient has chosen to be involved in some level of treatment, then solution focused individual and/or family therapy sessions begin. At any point the patient can choose to change their method of intervention.

In the follow-up of 250 patients and involved relatives, 50% reported abstinent (with family member confirmation) at four years after treatment, while 49.1% reported that they were abstinent at 5 years after treatment. After four years 23.5% of patients reported successfully practising controlled drinking, this figure rose to 25% after five years. For this research, controlled drinking was defined as three units of alcohol per day or less. For 57% of subjects who were still drinking after four years, and for 58.6% of subjects who were still drinking after five years, neither the patient nor their family thought the patient's drinking was still a problem. After five years 24.2% reported drinking was still a problem but saw it as far less of a problem than it had been.

Of the controlled drinking group, five years after treatment finished, 35% only drank on weekends or special occasions. When asked how they felt most of the time, 88.8% of patients reported feeling good five years after therapy. Overall, 25% of patients reported having relapsed at one time. This figure is very low considering that relapse is frequent within addiction treatment. This is valuable research when it is

remembered that family members agreed with the patient's feedback to the researchers. It is also notable when compared with the 1980 study on alcoholism treatment, which found that four years after treatment only 7% of patients remained abstinent. The uniqueness of Isebaert and de Shazer's study is that the patient is able to make the choice about whether abstinence is the best treatment plan for them. The research suggests the importance of respecting the patient's own ideas about how to reach their goal, which is a core value in the model of Solution Focused Brief Therapy. This exciting research project develops several ideas about differing interventions into addictions, most notably giving the clients the choice of treatment. However, that lack of comparative research makes strong interpretations from this research difficult. It will be interesting to see if the results can be replicated in following research at this treatment centre.

Training Impact on Clinical Work

An interesting report investigates the impact of training professionals in the model of Solution Focused Brief Therapy (Sudmann, 1997). This project used nine social workers in an experimental group which received basic training in solution focused ideas while the control group of nine social workers continued in their usual practice. The subsequent sessions with clients of both groups were taped and questionnaires were distributed to the two groups six months after training. The experimental group reported more positive

statements, were more goal focused and had more shared views regarding the intervention.

In research conducted at an adolescent residential facility staff received training in Solution Focused Brief Therapy. After the training adolescents in the residential facility were involved in 66% fewer incidents and used less medication than the control group (Triantafillou, 1997). This finding was reported sixteen weeks after the training intervention.

These studies support the idea that training mental health professionals in the model of Solution Focused Brief Therapy impacts on the professional, their view of their work, (Sudmann, 1997) and the population they work with (Triantafillou, 1997). However it is difficult to determine if the positive change reported was due to the training in general or the solution focused aspect.

Forthcoming Research

In addition to the published research projects listed above there are several research projects currently on-going. They range in scope from examining the process of the therapy; using the model in the context of an Employee Assistance Programme in relation to alcohol use; using the model in group work, and looking at the attitudes of alcohol counsellors to the techniques of the model. Currently, there is a project in Helsinki comparing solution focused interviewing to psychiatric problem focused interviewing and a project in Bamberg

looking at qualitative changes in gender and self-perception in relation to disability (Macdonald, 2000).

Review of Existing Research

It is clear that development of research on the model of Solution Focused Brief Therapy is on-going and the body of knowledge in relation to this model is expanding. The trend in research is moving away from earlier models of collecting data using clients' self perception (Burr, 1993; de Shazer et al., 1986; Macdonald, 1994) towards the use of standardised measurements and control groups (Johnson & Shaha, 1996; Lindforss & Magnusson, 1997) to compare and contrast the effectiveness of the model against other therapeutic interventions. The range of presenting problems and settings that the research spans demonstrates the wide application of the model in relation to the therapeutic world.

The research reviewed above has pointed out the use of the model in as far ranging as mental health facilities (Eakes et al., 1997; Macdonald, 1994; Macdonald, 1997; Triantafillou, 1997; Vaughn et al., 1996b); school settings (Morrison et al., 1993; Thompson & Littrell, 2000); working with children and adolescents (Burr, 1993; Franklin et al., 1998; Littrell et al., 1995; Wheeler, 1995); group therapeutic work (LaFontain & Garner, 1996; Lee, Greene, Uken, Sebold, & Rheinscheld, 1997a; Vaughn, Hastings-Guerrero, & Kassner, 1996a; Zimmerman et al., 1996 (Behan et al., 2000)); alcohol addiction

(Isebaert & de Shazer, unpublished); orthopaedic rehabilitation (Cockburn et al., 1997); multicultural counselling (Curz & Littrell, 1998), social work (Sudmann, 1997); prison services (Lindforss & Magnusson, 1997), and general counselling settings (de Shazer, 1985; de Shazer, 1991b; DeJong & Hopwood, 1996; George, Iveson, & Ratner, 1990; Johnson & Shaha, 1996; Lambert, Okiishi, Finch, & Johnson, 1998; Lee, 1997).

The existing research covers a wide range of client populations, presenting problems and reports healthy changes and satisfaction with the model of Solution Focused Brief Therapy. However, it is important to highlight that the majority of the research presented are uncontrolled studies using human judgement as the indicator of improvement. It would be significant to note this limitation of the research currently available on the model of Solution Focused Brief Therapy. There are only a few publications available that use a methodology with both a control group and data collection that is objective (Eakes et al., 1997; Johnson & Shaha, 1996; Vaughn, Hastings-Guerrero, & Kassner, 1996a). It is also important to highlight the difficulty in interpreting the body of research as a whole. The wide range of interventions and types of services makes analysis from one publication to another difficult. It is not until there is a wider base of research into solution focused brief therapy that is controlled, objective, and replicated that strong conclusions can be drawn on the model's effectiveness in the therapeutic world.

Materials

The research project outlined in this paper was developed to provide an outcome study into the model of Solution Focused Brief Therapy to establish if the SFBT model is effective in increasing clients' coping abilities with the problems that they are presenting to counselling.

The researcher met with sixteen therapists from six different counselling agencies in the United Kingdom to establish the research design and choose the materials for data collection. A research protocol was developed with the therapists to ensure the greatest possible ease in distributing questionnaires to subjects and to ensure quality control in the data received. Some of the counselling agencies had ethical committees that were applied to before permission was granted to use clients from their agency in the research project. After application all ethical committees agreed to establish the research project in their counselling agencies.

Before clients started with therapy sessions they were asked if they were willing to participate in a research project measuring the outcomes of Solution Focused Brief Therapy. If they agreed they were asked to read and sign a form stating that they agreed to take part in the research project and describing what would be required of them. This release form highlighted that the participants were free to discontinue with the research project at any point and emphasised that

their identity would never be at risk (Appendix 1). It was important to allow clients to discontinue with the research so that they did not feel intimidated into participating and to reassure them that they would still be able to access services if they did not continue to participate. Some of the counselling agencies used were within the National Health Service (NHS) of England and clients needed to be aware that non-participation would not limit their access to services. If the client was willing to participate they signed the form and filled in the Coping Resources Inventory (Appendix 2).

The Coping Resources Inventory (CRI) is a 60-item measure that assesses individuals' coping resources (Hammer, 1988). Coping resources are defined by the test as:

> "resources inherent in individuals that enable them to handle stressors more effectually, to experience fewer or less intended symptoms upon exposures to a stressor, or to recover faster from exposure."

When the research project was being developed there were several instruments considered that measure general mental "well being" and health. Two of the instruments considered were the Beck Depression Inventory (BDI) (Beck, 1978) and the General Health Questionnaire (GHQ) (Goldberg, 1981). It was decided to use the Coping Resources Inventory because it measured perceived coping of the client, which the model of SFBT tries to reinforce. Another main factor for choosing the Coping Resources Inventory was that it emphasised the client's

strengths and the questions revolved around how well the client felt they were doing, as opposed to many of the other psychometric tests explored. The other tests emphasised illness or deficits within the client's ability to cope. An example of a question from the Beck Depression Inventory (Beck, 1978) follows:

Beck Depression Inventory

I do not feel sad.

I feel sad.

I am sad all the time and I can't snap out of it.

I am so sad or unhappy that I can't stand it.

Here is a question from The General Health Questionnaire (Goldberg, 1981):

The General Health Questionnaire

Have you recently been thinking of yourself as a worthless person?

Not at all.

No more than usual.

Rather more than usual.

Much more than usual.

Contrast the above with sample questions from the Coping Resources Inventory (Hammer, 1988):

Coping Resources Inventory

I seek to grow spiritually:

Never or rarely.

Sometimes.

Often.

Always or almost always.

I can express my feelings to close friends:

Never or rarely.

Sometimes.

Often.

Always or almost always.

The questions from the Coping Resources Inventory are developed around what the subject is *able to do* instead of what they are *not able* to manage. In developing the measurement to be used in the collection of data the therapists involved felt strongly that the measures should reflect the ethos of the model and develop individual's strengths, skills, and resources. The Coping Resources Inventory was the best standardised measure that reflected the ideology of the therapeutic model available at the time of commencing the research. In developing the protocol using an instrument that would have provided a higher level of validity and reliability was considered secondary to using an instrument that fit the rationale of the treatment being applied.

The sixty items on the Coping Resources Inventory measure resources in five domains: cognitive, social, emotional, spiritual/ philosophical, and physical.

Cognitive

According to the Coping Recourses Inventory the cognitive scale of the CRI measures the extent to which individuals maintain a "positive sense of self-worth, a positive outlook towards others, and optimism about life in general" (Hammer, 1988). Representative question: "I feel as worthwhile as anyone else."

Social

The social scale of the Coping Resources Inventory measures the degree to which "individuals are imbedded in social networks that are able to provide support in times of stress" (Hammer, 1988). Representative question: "I am part of a group, other than my family, that cares about me."

Emotional

The emotional scale of the Coping Resources Inventory measures the degree to which "individuals are able to accept and express a range of affects, based on the premise that a range of emotional response in ameliorating long-term negative consequences of stress" (Hammer, 1988). Representative question: "I can cry when sad."

Spiritual/Philosophical

The spiritual/philosophical scale of the Coping Resources Inventory measures the degree to which "actions of the individual are guided by stable and consistent values derived from religious, familial, or cultural tradition or from personal philosophy. Such values might assist to define the meaning of potentially stressful events and to prescribe strategies for responding effectively. The content domain for this scale is broader than traditional western religious definitions of spirituality" (Hammer, 1988). Representative question: "I know what is important in life."

Physical

The physical scale of the Coping Resources Inventory measures the degree to which "individuals enact health-promoting behaviours believed to contribute to increased physical well-being. Physical well-being is thought to decrease the level of negative responses to stress and to enable faster recovery. It may also help to attenuate potentially chronic stress-illness cycles resulting from negative physical responses to stressors that themselves become major stressors" (Hammer, 1988). Representative question: "I exercise vigorously 3-4 times a week."

It is a combination of these five scales: cognitive, social, emotional, spiritual/philosophical, and physical that make up the subject's overall score for each test they take (Hammer, 1988).

Administration

The Coping Resources Inventory is a paper test that consists of a question booklet and an answer sheet. The answer sheet is filled in using a number two pencil to fill in circles next to the corresponding answers. A number two pencil has a special lead that allows the test to be computer scored. This type of test scoring sheet is referred to as a scantron scoring sheet. The inventory normally takes 10 minutes to complete. In the instructions the subject is asked to answer every item on the test. The Coping Resources Inventory is considered valid for subjects aged from fourteen to eighty-three years of age (Hammer, 1988).

Scoring

For "each of the 60 items, respondents use a 4-point scale to indicate how often they have engaged in the behaviour described in the item over the past six months. Scale scores are simply the sum of the item responses for each scale. Points for six items with negative working must be reversed" (Hammer, 1988).

Scoring was conducted using a hand-scoring template provided by Consulting Psychologists Press, the publishers of the instrument. When answers had been omitted the individual's score was prorated by multiplying the raw score for the items that were answered by the total number of possible items, then dividing by the number of items answered and rounding to the nearest whole number. This would only

hold true if fewer than two questions were omitted. If there were more than two questions omitted the individual test was considered invalid.

All raw scores were converted to standard scores to be able to compare and contrast the various scales and overall score on the inventory. The instrument indicated that approximately 95% of individuals would have standard scores that fall between thirty and seventy. Owing to gender difference, separate conversions from the raw score to the standard score exist for men and for women.

Ten percent of the Coping Resources Inventory was re-scored by hand by the original researcher who scored the instrument to ensure that the test scoring was accurate and reliable. There were seventy-two Coping Resources Inventory tests scored during the research. In the re-scoring of the test, seven tests were scored with 100% correlation between the first scores and the second scores. This suggests that the method of scoring the Coping Resources Inventory was reliable.

Interpretation

The scores can be interpreted in several ways. An individual may have a low overall scale indicating that their overall belief in their ability to cope is low. On the other hand, their score may only dip below average for one scale in the test, for example the physical scale. This would indicate that the individual might be having difficulty with one aspect of coping resources.

Reliability

Item-to-scale correlation

The item-to-scale correlations for 749 subjects is outlined in the chart below: These correlations indicate to the developers of the Coping Resources Inventory that they were successful in achieving "fairly good homogeneity of item content per scale."

Scale	**Median**
Cognitive	.46
Social	.45
Emotional	.46
Spiritual/Philosophical	.42
Physical	.37
Total	.39

Internal consistency

The developers of the Coping Resources Inventory state, "the range and pattern of the reliabilities suggest that the CRI scales are fairly homogeneous and are reliably tapping the constructs".

Test-retest

The developers of the Coping Resources Inventory have a small sample (n=115) of test-retest reliability data. In this retest over a six-week period the data shows a stable score. This result should be interpreted with caution owing to the small sample for test-retest reliability.

Validity

Predictive validity

To test the validity of the Coping Resources Inventory, Elkind's Stress Test for Children (Elkind, 1981) and the Personal Stress Symptom Assessment (PSSA) (Numeroff, 1983) were used in comparison with the Coping Resources Inventory. After comparative testing the Coping Resources Inventory total resource score seemed to make a significant contribution to the predication of symptoms (Hammer, 1988)

Overall validity was tested using a wide range of other measurement instruments including: Brief Symptom Inventory (Derogatis & Spencer, 1982), Health and Daily Living Form (Billings & Moos, 1981), Pennebaker Inventory of Limbic Languidness (Malone & Haley, 1985), Beck Depression Inventory (Beck, 1978), Texas Grief Inventory (Visook, Devaul, & Click, 1982), Marlowe-Crown Social Desirability Scale (Hammer, 1988), and the Myers-Briggs Type Indicator (Myers & McCaulley, 1985).

For the purposes of this research, it is worth comparing the Coping Resources Inventory with the Beck Depression Inventory, as this was one of the alterative testing instruments considered in the original research design.

Correlation of CRI Scales with the Beck Depression Inventory

Cognitive	Social	Emotional	Spiritual	Physical	Total
- .44	- .45	-.49	- .39	-.62	- .66

This correlation was developed by administering the CRI along with a battery of other instruments, including the Beck Depression Inventory, to a small sample (n=21) of individuals who had been the primary care-giver for family members who had died of Alzheimer's disease (Malone & Haley, 1985). The correlation was developed using a small sample size and should be interpreted with caution.

Upon the bases of the data above, the developers of the Coping Resources Inventory consider the instrument a valid and reliable measure to collect data to measure subjects' perceived coping with stressful events in their life.

Instruments of Data Collection

Other instruments that were used to collect data were the Client Perception Questionnaire (Appendix 3) and the Therapist Perception Questionnaire (Appendix 4). If the subject attended these instruments

were administered at the fourth session, to ascertain client and therapist's perceptions of helpful interventions during the therapeutic session. The client and therapist were asked to rate on a scale of one to ten how much time was used during sessions in relation to various interventions and how helpful these interventions were. One is the lowest of the scale score and ten is the highest. The questions that were asked follow:

1) How much of the time in the session was spent talking about the past?
2) How helpful was it to talk about the past?
3) How much of the time in the session was spent talking about the present?
4) How helpful was it to talk about the present?
5) How much of the time in the session was spent talking about the future?
6) How helpful was it to talk about the future?
7) How much time was spent talking about where you were on a scale from 0-10?
8) How helpful was it to talk about where you were on a scale from 0-10?
9) How much of the time was spent talking about what you were already doing right?
10) How helpful was it to highlight what you were already doing right?

11) How much of the time was spent talking about how you would like life to be?

12) How helpful was it to talk about how you would like life to be?

There was a pilot study of ten subjects. The Therapist Perception Questionnaire and the Client Perception Questionnaire were administered to assess if the instrument was useable and accessible to the client population being studied. After the pilot study of ten questions the researcher was given the feedback from the therapists that the questionnaire seemed easily understood and useable for the subjects.

Design and Procedure

The design of the research project was developed with the sixteen therapists that were to distribute the Coping Resources Inventory to subjects that presented at their counselling centres.

Selection of Therapist to Collect Data

Therapists who believed that they were practising the model of Solution Focused Brief Therapy and had completed training in that model of therapy were asked to participate in the collection of data.

Graph of Therapists and Agencies

Therapist	Team	Age	Sex	Race	Working in a Team	Years in Practice	Type of Agency
A	A	44	Male	White	Yes	15	Private
B	A	50	Male	White	Yes	24	Private
C	A	42	Male	White	Yes	15	Private
D	B	46	Male	White	Yes	21	NHS Addiction
E	B	35	Female	White	Yes	3.5	NHS Addiction
F	B	40	Male	White	Yes	4	NHS Addiction
G	B		Female	White	Yes	13	NHS Addiction
H	B	30	Female	White	Yes	.5	NHS Addiction
I		50	Male	White	No	15	Private
J		58	Female	White	No	11	Private
K		42	Male	White	No	17	Private
L	C	51	Female	White	Yes	7	NHS Psychiatric
M	C	28	Female	White	Yes	1.5	NHS Psychiatric
N	C	39	Female	White	Yes	4	NHS Psychiatric
O	C	35	Male	White	Yes	4	NHS Psychiatric
P	C	32	Female	White	Yes	4.5	NHS Psychiatric

The profile of the therapists that collected the data is as follows:

There were three teams of therapists collecting data. This meant that each therapist worked in a team of therapists all of whom practised Solution Focused Brief Therapy, often seeing clients in a team with the use of a one-way mirror or video link up. This way of working was explained to the client and was done with the client's permission. Not all clients who presented to teams were seen in a team fashion. There were three therapist teams, one team had three

members (all male), the second team had five members (three female, two male), and the third team had five members (four females, one male). An additional three therapists practised on their own in private practice, two males and one female. There was an even division between male/female data collection as there were eight female and eight male therapists. The therapists ranged in age from twenty-eight to fifty-eight and the average age was forty-two years old. All the therapists that participated in the data collection were white Europeans. All the therapists participated in on-going supervision in relation to their clinical work. However, each therapist's training and experience ranged widely. The number of years' experience practising as a therapist ranged from one year to twenty-four years. The mode number of years in practice was four years and the average was ten years in practice. The therapist's number of years in practice did not mean that they were practising in the model of Solution Focused Brief Therapy for this length of time.

The 1997 article What Works?: Remarks on Research Aspects of Solution Focused Brief Therapy by de Shazer and Berg was published during the collection of data for this research project (de Shazer & Berg, 1997). In this article, de Shazer and Berg outline the minimum requirements for a therapeutic session to be considered solution focused therapy for research purposes. The four criteria laid out are:

1) At some point in the first interview, the therapist will ask the Miracle Question.
2) At least once during the first interview and at subsequent ones, the client will be asked to rate something on a scale of one to ten.
3) At some point during the interview, the therapist will take a break.
4) After this intermission, the therapist will give the client some compliments, which will sometimes (frequently) be followed by a suggestion or homework task (frequently called an experiment).

De Shazer and Berg's questions were sent to all the therapists involved in the data collection, after the collection of data had begun. Of the sixteen therapists, ten filled in the form and returned it to the researcher. This constitutes 63% of the participating therapists. Here are the responses to the questions asked of them:

1) At some point in the first interview do you ask the Miracle question?

- (80%) eight therapists answered "yes"
- (10%) one therapist answered 90-95 % of the time
- (10%) one therapist answered 75-80% of the time

2) At least once during the first interview and others do you use scales?

- (80%) eight therapists answered "yes"
- (10%) one therapist answered 95% of the time
- (10%) one therapist answered 80-90% of the time

3) Do you take a break?

- (80%) eight therapists answered "yes" or "almost always"
- (10%) one therapist answered 60-70% of the time
- (10%) one therapist answered "Not Always"

4) After the break do you give compliments, which frequently are used to suggest tasks?

- (90%) nine therapists answered "yes"
- (10%) one therapist answered, "Compliments always – tasks rarely"

From this data it was determined that the majority (63%) of therapists involved in the data collection for the project were participating in Solution Focused Brief Therapy, as defined by de Shazer and Berg, for the majority of their practice (de Shazer & Berg, 1997). The data collection for this project had already begun and the set protocol was established in the collection of data when de Shazer and Berg's article outlining the four criteria was published. The research design may have been altered if this information was available before the start of the project.

In addition, the more recent European Brief Therapy Association (EBTA) research meeting in Bruges (EBTA, 1999) decided that for a research publication to be considered Solution Focused Brief Therapy it must include the following techniques from the model: goal setting, exception questions, pre-session changes, exploration into the client's resources, the miracle question, scaling questions, compliments to the

client, and tasks assigned to the client. The second session and other return sessions must begin with the questions "What is better?" or another similar question. Although in this research project these guidelines were not set down before the collection of data, the therapists involved in the collection of data would have used all these techniques of the model on a regular basis.

Each counsellor who participated in the research project was briefed on the standard procedure involved in the collection of data. They were informed that subjects to be involved in the research project should include any client that presented to the counselling centre or private practice over 18 years of age for individual counselling. Any clients coming to counselling as a couple or family were not included in this research project. Each counselling agency was given envelopes for each subject, containing all the relevant instruments and forms. Each envelope included a solution focused research check-list (Appendix 5) that outlined the standard procedure to be followed by the therapist.

When a client over 18 years of age presented to the agency for individual counselling, the counsellor would ask the client if they were willing to participate in a research project. The counsellor was to make it clear to the client that non-participation in this project would not affect their access to the counselling service. If the client agreed to participate in the research project the counsellor would take a new envelope and assign it to the subject. Each envelope of research

material was client-coded and the counsellor was asked to note the subject's code on the counsellor's own documentation for their own cross-referencing. Each counsellor was assigned a therapist code before the research project began. The counsellor was asked to note his or her own therapist code on the front of the envelope of information. This coding system was developed to ensure confidentially for subjects participating in the research project.

Before the First Counselling Session

Inside the envelope for each subject was a small envelope labelled *Before Start*. The therapist was instructed to either send this envelope of information to the subject before they attended their first session or the subject was asked to come to the counselling agency fifteen minutes before the start of their first session to fill in the relevant forms. This variation in the collection of the first measure depended upon the availability of a pre-session area for the subject to be able to read through and fill in the forms required for the research project. The envelope entitled *Before Start* had a release form (Appendix 1) outlining the research to the subject and gaining the subject's address and their written permission to continue with the data collection. The envelope also included a copy of the Coping Recourse Inventory test booklet, answer form and a number two pencil. The number two pencil was supplied for subject convenience. The directions for administration were printed on the Coping Resources Inventory and read as follows:

"*For each of the sixty statements that follow, fill in the circle on your answer sheet that best describes you in the last six months. For each statement mark one of the following descriptions:*

Never or rarely

Sometimes

Often

Always or almost always

Do not make any marks in this booklet. Mark all of your answers on the separate answer sheet. It is important that you try to answer every question."

The subject was asked to return the release form and the Coping Resources Inventory and scoring form to the therapist at their first meeting.

The therapist was asked to keep the release form with their copy of the subject's notes and to keep the Coping Resources Inventory in the larger envelope for collection once the subject had completed all forms. To ensure confidentiality of the subjects the release form was kept with the therapist's notes and not returned to the researcher. Therefore the researcher was only informed of the subject's relevant demographical information in the data collection and not the subject's identity.

After the first session the therapist was asked to fill in the *Client Information Sheet* (Appendix 6). This form collects demographic information with regard to the subject's age, sex, type of presenting

problem, and whether they have received any intervention in the past in relation to the presenting problem. The therapist then carries on with their counselling intervention in the usual way.

After the Fourth Session

If the subject returns for a fourth session, after the session they are asked to fill in two forms: 1) the Coping Resources Inventory for a second time and the 2) Client Perception Questionnaire (Appendix 3). When the subject has completed the forms they are to enclose and seal the forms in an envelope provided to them. The subject is asked to return the sealed envelope to the therapist.

After the fourth session the therapist is asked to fill in the Therapist Perception Questionnaire. The perception scales for both the subject and the therapist are to assess what they felt was a useful intervention within the therapy session. The therapist was asked to put the subject's Coping Resources Inventory, the sealed envelope, and their own copy of the therapist's perception scale into the larger envelope for collection at a later date. The collection of data from the Client Perception Questionnaire and the Therapist Perception Questionnaire are done blind, meaning that the client does not see the therapist's answers and the therapist does not see the client's answers. This is to ensure that subject and therapist answers do not influence each other.

Three Months After the Final Counselling Session

Three months after the final counselling session had taken place the therapist was asked to retrieve a different information envelope entitled *Three-month Follow-Up* from the large envelope of data collection . The therapist was instructed to send this envelope to the subject at the address specified on the release form. Once this envelope has been sent to the subject, the remaining information included in the larger envelope was to be sent back to the researcher at City University's Psychology Department.

The larger envelope included the following items:

- Coping Resources Inventory taken before the first session.
- Client Information Sheet including client demographics and the therapist code.
- Coping Resources Inventory taken after the fourth session (if the fourth session was attended).
- Client Perception Questionnaire (if fourth session attended).
- Therapist Perception Questionnaire (if fourth session attended).

The *Three-Month Follow-Up* envelope that was sent to the subject after completion of counselling included:

- An instruction note to the subject (Appendix 7) asking the subject to fill in the relevant forms and to send them back to the University in the pre-paid addressed envelope.
- Coping Resources Inventory test booklet and answer sheet.

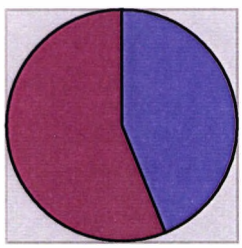
- Number 2 pencil.
- Pre-paid addressed envelope to mail the relevant information back to the researcher at the Psychology Department at City University.

The data was then collected at the Psychology Department of City University from the various therapists' collecting data and subjects that completed the three-month follow-up forms. The Coping Resources Inventory was hand scored as outlined above and the relevant data regarding subject demographics, Coping Resources Inventory, Client Perception Questionnaire, and the Therapist Perception Questionnaire were all turned into raw data. This data was input into the software package SPSS 8.0 for data analysis (SPSS, 1998).

Subjects

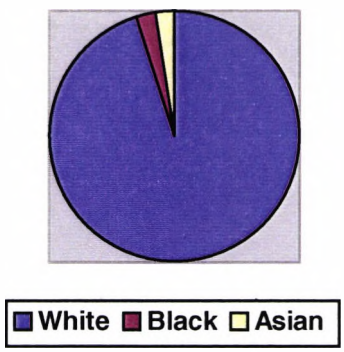
The subjects of this study were clients accessing counselling between the dates of December 1996 to September 1998 via private counselling, a National Health Service (NHS) drug and alcohol addiction service, and a National Health Service (NHS) outpatient psychiatric service. Forty-five subjects initially agreed to participate in the research. The subjects ranged in age from eighteen to sixty-one years old. The mean age of the subjects was 36.14, where the median was thirty-five and the mode was thirty-seven. Of the forty-five subjects, 44% (N20) were male and 56% (N25) were female.

Gender Split of Subjects



Of the subjects who answered questions in relation to their race (N43), 95% (N41) were white, 2.5% (N1) were black, and 2.5% (N1) were Asian.

Racial Mix of Subjects

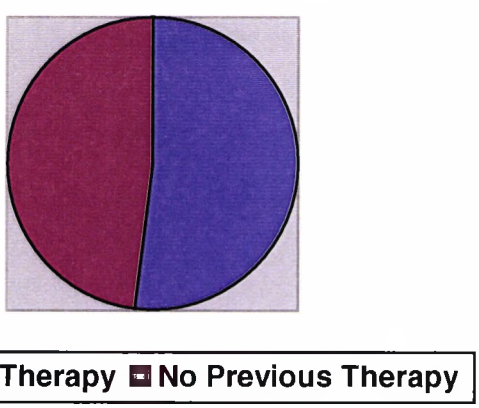


Of the subjects who answered questions regarding their employment status (N44), 66% (N29) of the subjects said they were employed and 34% (N15) stated they were unemployed.

Employment Status of Subjects

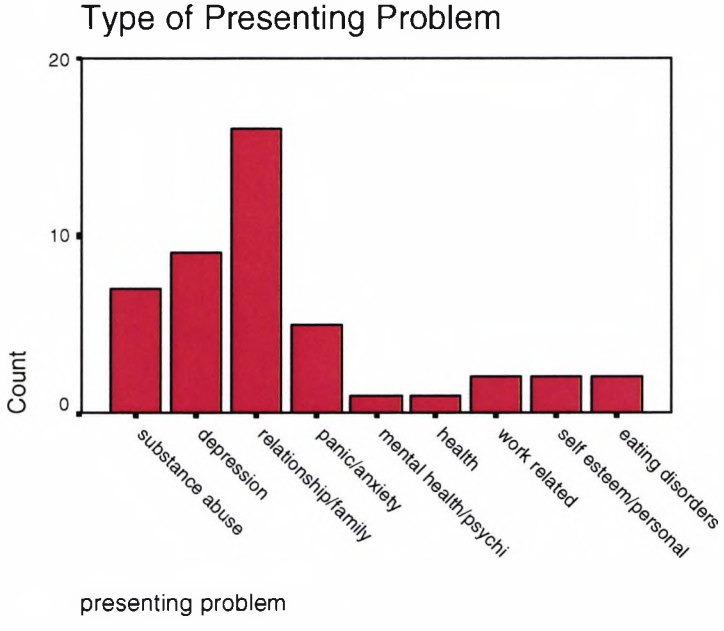
Of the subjects who answered questions about whether they had attended previous therapy for their problem (N44), 52% (N23) stated they had attended therapy in the past, and 48% (N21) stated that this was there first experience of counselling for this presenting problem.

Previous Intervention Split



With regard to types of presenting problem 36% (N16) stated that their presenting problem was in relation to their relationship or family and 20% (N9) stated that they were attending due to depression. Sixteen percent (N7) of subjects were attending for substance abuse

issues. All of the clients who presented with problems related to substance abuse attended the NHS Addiction Service. Panic and anxiety were related to 11% (N5) of the presenting problems. Work-related issues were listed by 4% (N2) of the subjects as the presenting problem and self-esteem/personal issues accounted for another 4% (N2) of the subjects. Eating disorders were listed by 4% (N2) of the subjects as the presenting problem, while 2% (N1) of the subjects listed their presenting problem as health-related, whereas only 2% (N1) of subjects listed their problem as mental health-related or psychiatric. Of the subjects who attend the NHS Psychiatric Day Hospital only one subject listed their problem as mental health/psychiatric.



After the initial demographical collection, thirty-seven subjects had completed and returned their Coping Resources Inventory forms before they began the therapeutic intervention. There are twenty subjects that completed the Coping Resources Inventory before

beginning therapy and also completed and returned the Coping Resources Inventory after the completion of therapy.

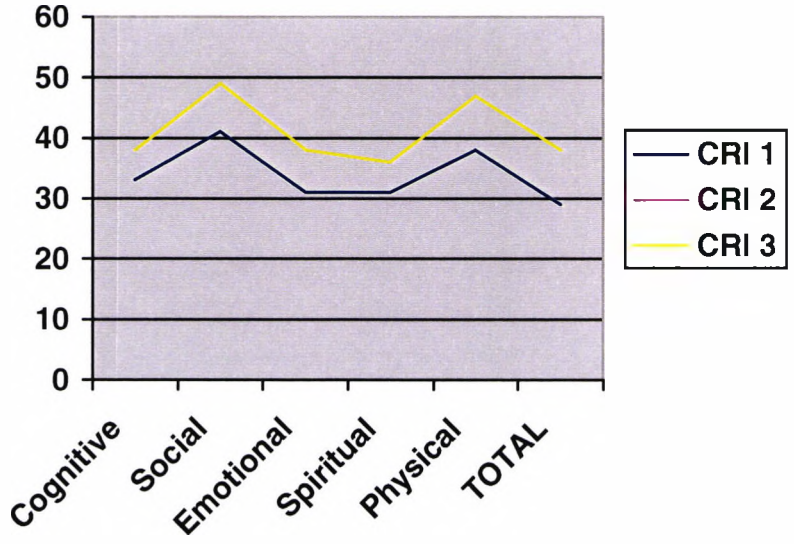
Results

During the development of the research project it was hypothesised that subjects would improve demonstrated by the data collected at the beginning of the therapeutic intervention (Coping Resources Inventory 1 (CRI 1)), during the therapeutic sessions (Coping Resources 2 (CRI 2)), and continue to improve at a three-month follow-up (Coping Resources Inventory 3(CRI 3)). The existing research already presented suggests that the model of Solution Focused Brief Therapy is successful in helping clients to meet their goals. Therefore, it was imagined that clients' scores on the Coping Resources Inventory would improve throughout the therapeutic intervention, suggesting that the model improves clients' perceptions of their ability to access their own strengths, skills, and resources to overcome their presenting problem using their coping resources.

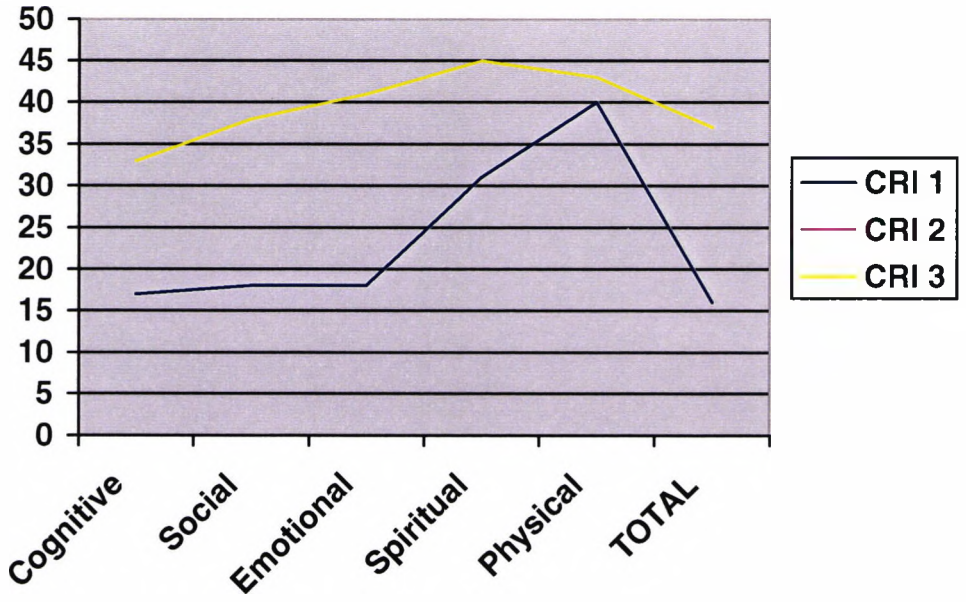
The following graphs highlight the expected results of the data collection. These are graphs of the data collected on four of the subjects whose scores were significantly improved as defined by the Coping Resources Inventory. The Coping Resources Inventory instructs a confidence band value of +12.8 on the raw total score to construct a 95% confidence interval for individual scores. This implies that if a subject's raw total score moves by 12.8 points, one can be

95% confident that this score is significant as defined by the Coping Resources Inventory.

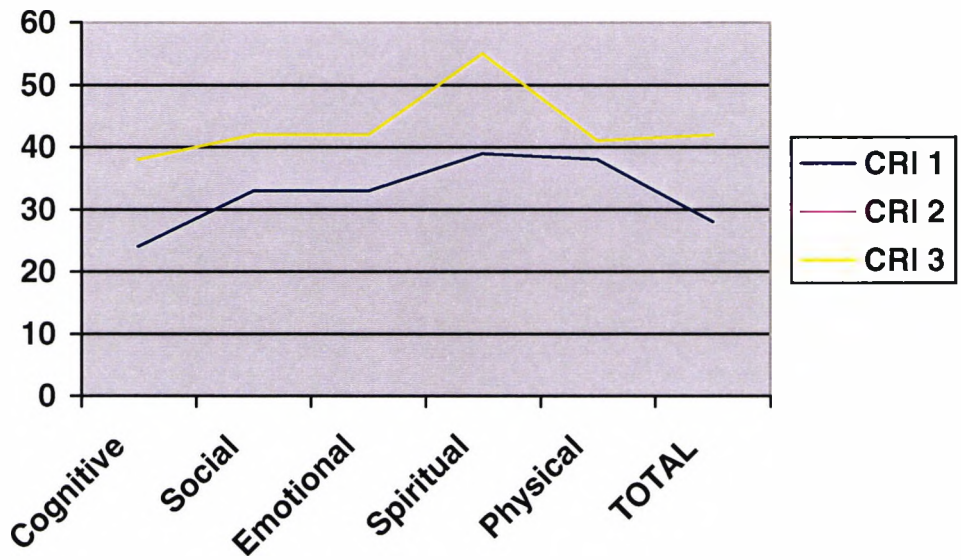
Subject 7



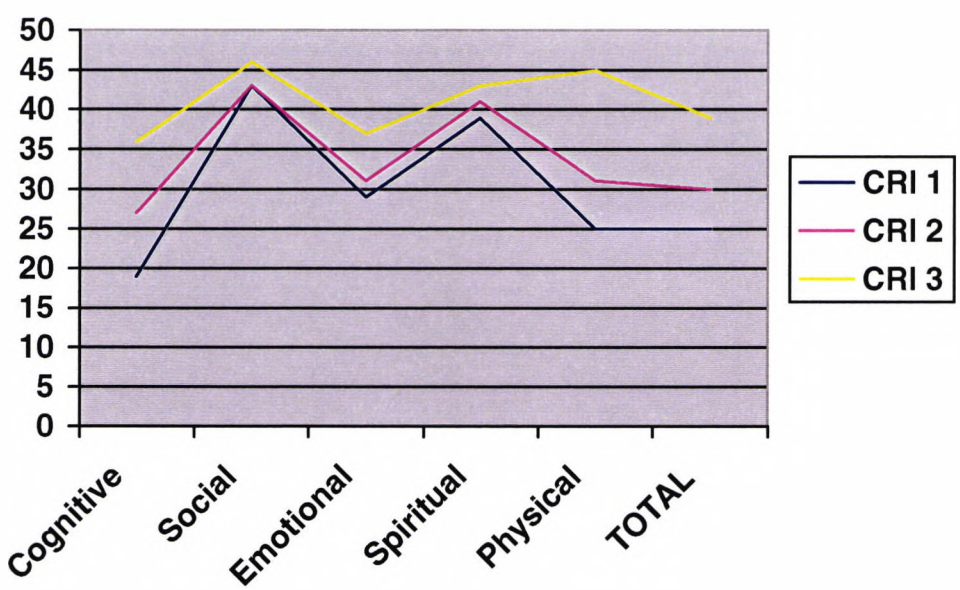
Subject 8



Subject 16



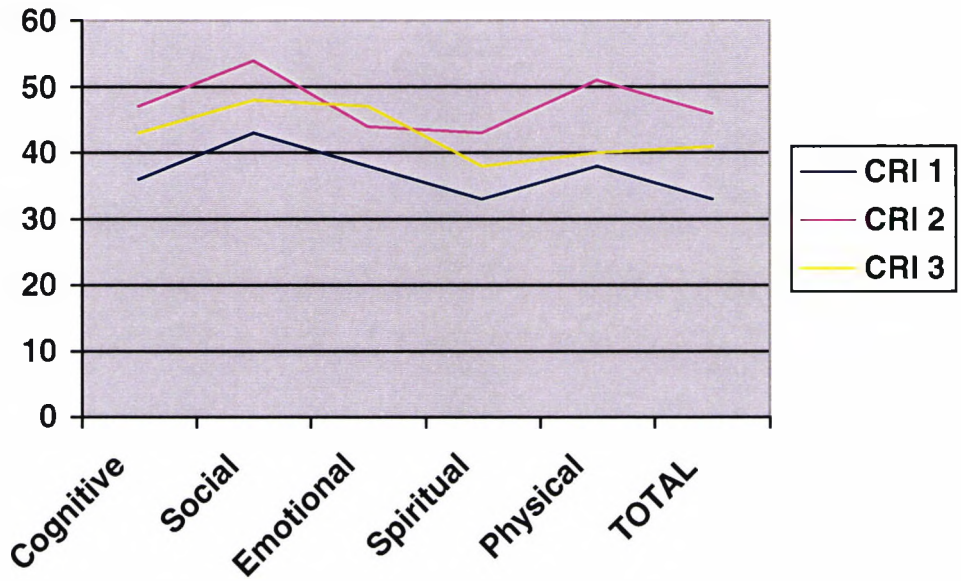
Subject 100



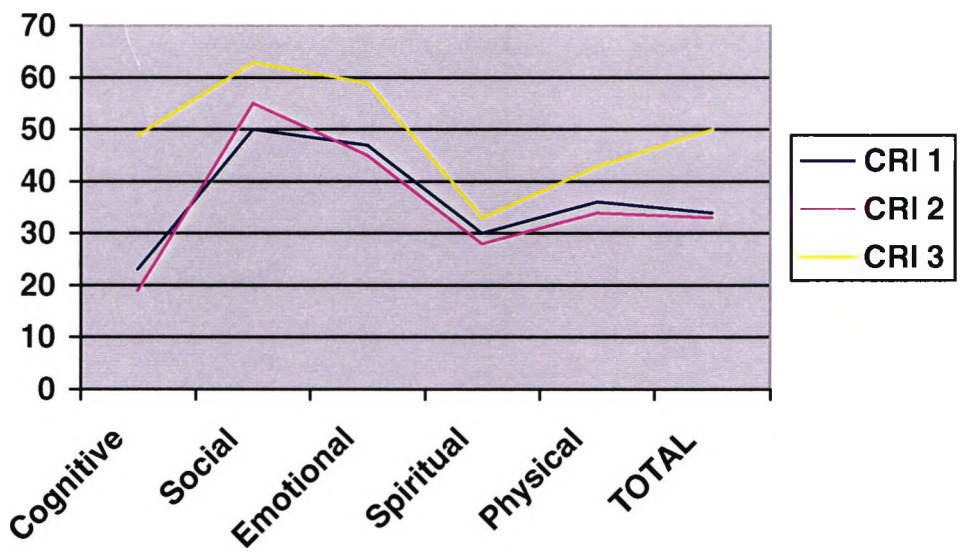
The graphs illustrate that the subjects' scores increased from the time they attended the first session (CRI 1) compared to the three-month follow-up (CRI 3). As expected the subjects' scores increased across all sub-scales at a fairly consistent rate. Although these four graphs demonstrate the hypothesis that subjects' coping resources improve over the duration of therapy and at a three-month follow-up, they represent only a small sample 20% (N4) of the data collected (N20). Of the 20 subjects that provided Coping Resources Inventory scores before starting therapy and three months after the termination of therapy only half (N10) showed significant improvement as defined by the Coping Resources Inventory. There was also confusion regarding the results of the second Coping Resources Inventory score (CRI 2). There did not seem to be a progressive improvement of most of the subjects' CRI 2 scores. Many of the subjects' second CRI score were the same or worse than the first CRI score.

The following graphs demonstrate that in subjects that did improve significantly between their first Coping Resources Scale (CRI 1) and their follow-up score (CRI 3), it was not a progressive improvement, as highlighted by the scores collected during the fourth session of therapy (CRI 2).

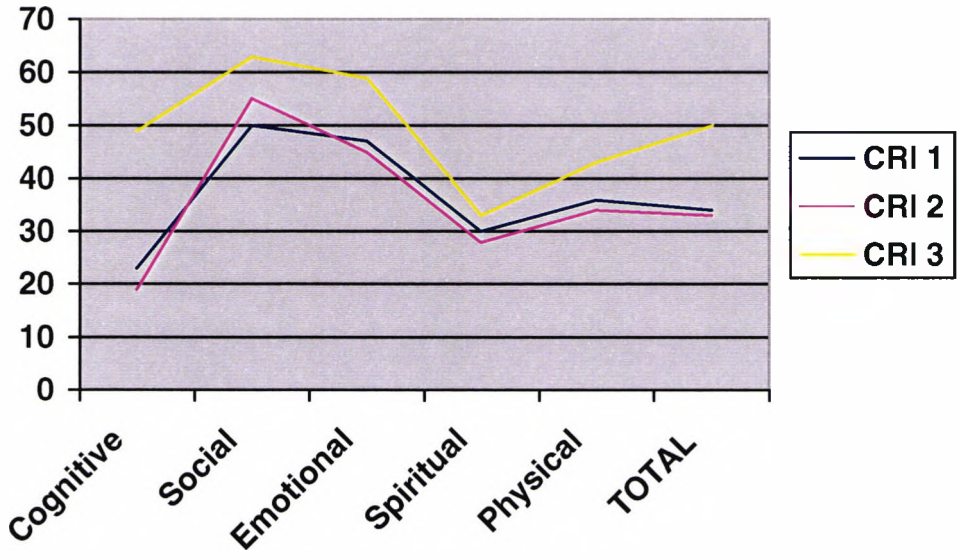
Subject 63



Subject 86



Subject 99

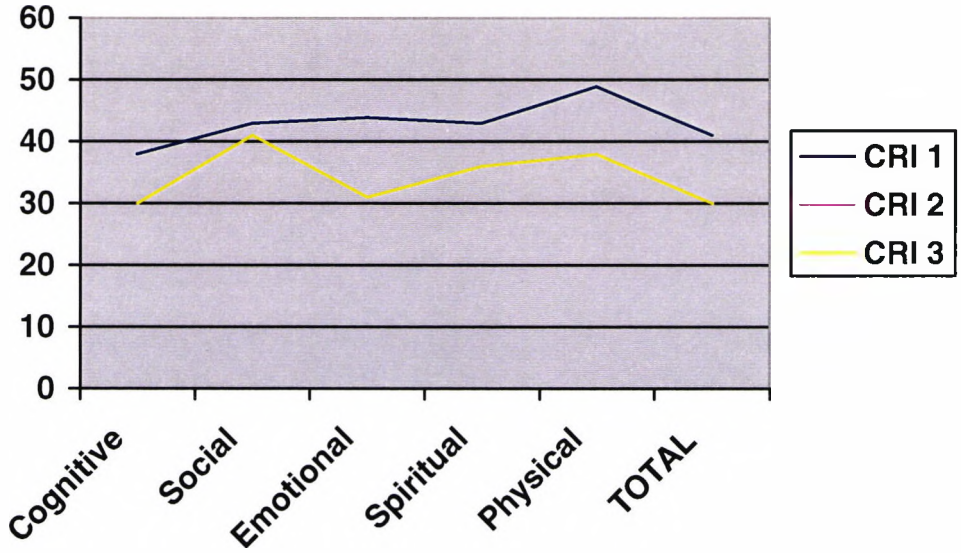


It is demonstrated by these graphs that the improvement on the Coping Resources Inventory was not progressive in the majority of cases. Some subjects' Coping Resourses scores were less during the therapy than before the therapy. Other subjects' scores improved greatly during the sessions, only to dip on the three months follow-up score.

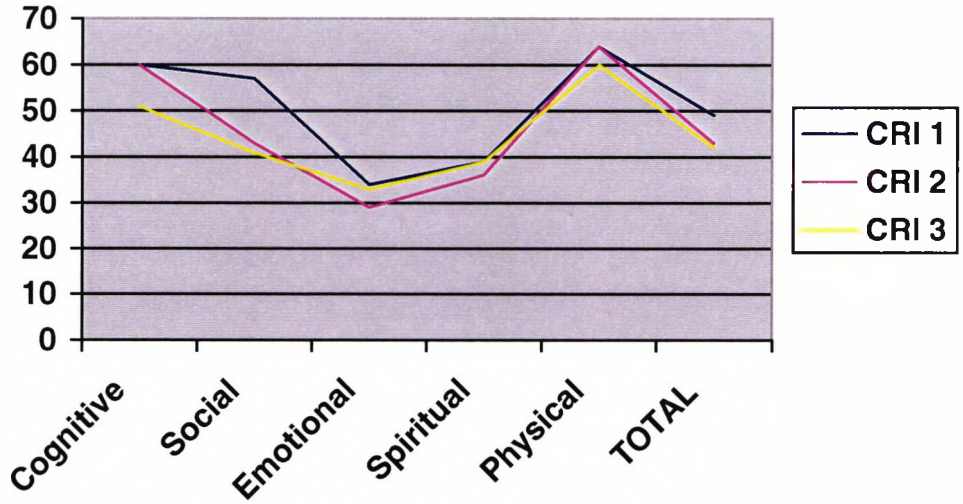
There were some of the subjects whose scores were significantly worse on the three-month follow-up (CRI 3) as compared to their scores before they began therapy. Of the twenty subjects that provided CRI 1 and CRI 3 scores, three did significantly worse on their follow-up scores. This reflects that 15% of the subjects in question perceived that they were coping to a lesser degree three months after

therapy than they were before they began attending the therapeutic intervention. The following graphs are of the three subjects:

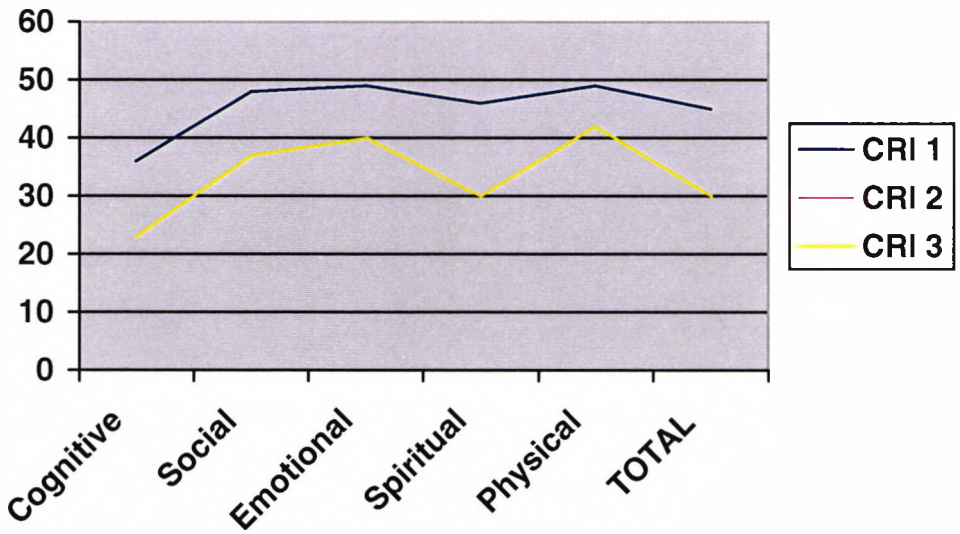
Subject 87



Subject 51



Subject 9

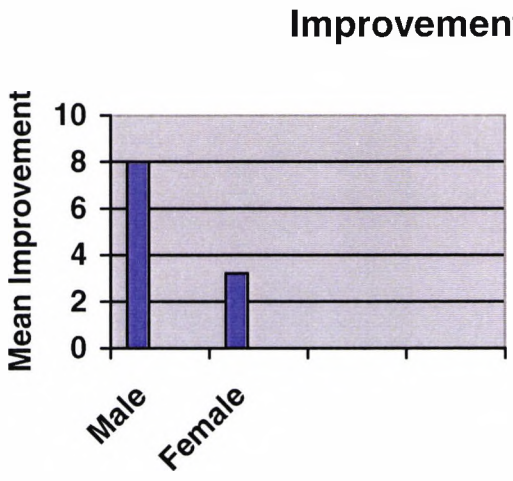


It is interesting to note that all three of the clients that did significantly worse were female subjects with presenting problems regarding relationship and/or marriage.

In conclusion, of the 20 subjects that are reviewed above only 50% (N10) showed significant improvement as defined by the Coping Resources Inventory (improvement of 12.8 points on the raw total score). Another 25% (N5) of subjects improved, but not significantly. One subject's scores remained the same, which is 5% of the sample, and another 5% (N1) reflected that their coping decreased but not significantly. There were three subjects, 15%, whose results suggest they were coping significantly worse three months after therapy than they were before starting therapy.

Another aspect of the data that was interesting was the comparison of male and female clients. The mean of the improvement

score (CRI 3 – CRI 1) on the total Coping Resources Inventory was different for male and female subjects. Males improved on average 8 points on the total Coping Resources Scale over time when females improved 3.22 points.



Although both males and females showed improvement on average, males improved more. However, neither male nor female improvements were up to the 12.8 level that the Coping Resources Inventory defined as being 95% confident of the change.

In addition to this examination, the data was analysed using the software package SPSS 8.0 (SPSS, 1998) in relation to the client's improvement over time and the variables. There was also interest in the similarities and differences between the client's and therapist's perceptions of lengths of time spent on various solution focused techniques and how helpful the client and therapist felt these interventions were. T-tests were run with a Bonferroni correction and

Mann-Whitney tests were run to establish the outcome of subjects, and what variables may have influenced this outcome. Originally the data was considered using t-tests. In the tables the T-tests are referred to in the table "T". There was little significant change in the data over time from this analysis. Due to the small sample size and the variance in the subject population analysis was run using Mann-Whitney tests. The Mann-Whitney tests are stated as "Z" in the tables that follow. The results from both these tests are shown on the following charts.

Improvement was defined as changes in Coping Resources Inventory (CRI) total scores from pre-therapy to three-month follow-up. Subtracting each Coping Resources Inventory sub-scale time 3 scores from each CRI sub-scale time 1 scores generated an improvement score. (20 people from the sample returned time 1 and time 3 scores.) This new variable was used to assess the impact of each of the following on changes in coping.

- Does client's age relate to improvement on overall scores? Each sub score?
- Does client's gender relate to improvement?
- Does Therapist's age relate to improvement on overall scores? Each sub score?
- Does Therapist's gender relate to improvement?
- Does the employment/non employment relate to improvement?
- Does being in therapy previously relate to improvement?
- Does the therapist's level of training relate to the level of improvement?
- Does if the therapist works in a team effect outcome CRI
- 1 overall – CRI 2 overall – CRI 3 overall

THROUGHOUT THIS SECTION, LEVELS OF SIGNIFICANCE ARE INDICATED THUS:

† = 0.10>p
* = 0.01<p<0.05
** = 0.001<p<0.01
*** = p<0.001

Therapist working individually or in a team

Analysis was run in relation to if subjects' outcomes were influenced by the fact the therapeutic intervention was with a team or an individual therapist.

Table of Means and Standard Deviations for Therapist working in a Team.

		Yes (n=13)	No (n=7)	Z	T
CRI Total	**M**	07.00	03.71	-1.072	.708
	SD	11.20	06.57		
Cognitive	**M**	08.86	04.28	-1.150	.979
	SD	10.96	07.47		
Social	**M**	04.23	00.28	-.637	.991
	SD	07.82	09.69		
Emotional	**M**	05.69	02.71	-.319	.613
	SD	11.39	07.91		
Spiritual	**M**	02.92	03.57	-.199	-1.69
	SD	09.54	04.31		
Physical	**M**	04.23	03.57	-.399	.187
	SD	08.62	04.54		

Notes: M= Mean, SD = Standard Deviation.

There were no significant results for this set of analysis.

This result suggests there is no difference in outcomes of subjects that were seen by an individual therapist or a team of therapists.

Therapist's Gender

Analysis was run to determine if there was significant differences between the outcome of male and female therapists.

Table of Means and Standard Deviations for Therapist's Gender.

		Male (n=9)	Female (n=11)	Z	T
CRI Total	**M**	05.55	06.09	-.076	-.119
	SD	10.05	10.02		
Cognitive	**M**	06.44	07.90	-.266	-.320
	SD	08.45	11.35		
Social	**M**	03.55	02.27	.000	.328
	SD	08.58	08.77		
Emotional	**M**	04.88	04.45	-.1.91	.092
	SD	10.36	10.55		
Spiritual	**M**	02.33	03.81	-.343	-.405
	SD	09.94	06.35		
Physical	**M**	03.11	04.72	-.459	-.481
	SD	06.58	08.11		

Notes: M= Mean, SD = Standard Deviation.

There were no significant results for this set of analysis.

This result suggests that there is no significant difference between the outcomes of male or female therapists.

Therapist's Level of Training

Analysis was run to determine if the therapist's level of training influenced the outcome of the subjects.

Table of Means and Standard Deviations for Therapist's Training Level

		Dip/MA/MS (n=9)	On the Job (n=11)	Z	T
CRI Total	**M**	06.33	05.45	-.076	.195
	SD	08.36	11.18		
Cognitive	**M**	07.00	07.45	-.190	-.099
	SD	08.86	11.14		
Social	**M**	01.22	04.18	-.420	-.767
	SD	08.88	08.32		
Emotional	**M**	05.33	04.09	-.267	.264
	SD	09.59	11.09		
Spiritual	**M**	04.88	01.72	-.723	.877
	SD	05.90	09.37		
Physical	**M**	05.66	02.63	-.841	.917
	SD	05.80	08.38		

Notes: M= Mean, SD = Standard Deviation.

There were no significant results for this set of analysis.

This result suggests that there is no significant difference in the outcome of subjects in relation to the level of training their therapist had completed

Subject's Socio-Economic Status

Analysis was run to determine if the subject's socio-economic status, as defined by employment, influenced outcome.

Table of Means and Standard Deviations for Clients' Employment

		Employed (n=15)	Unemployed (n=5)	Z	T
CRI Total	**M**	03.93	11.60	-1.487	-1.57
	SD	09.77	08.01		
Cognitive	**M**	04.93	14.20	-2.097*	-1.93†
	SD	10.10	05.44		
Social	**M**	02.33	04.40	-.307	-.462
	SD	09.30	05.94		
Emotional	**M**	03.13	09.20	-.966	-1.16
	SD	10.27	09.47		
Spiritual	**M**	02.40	05.40	-.656	-.720
	SD	07.89	08.64		
Physical	**M**	02.00	10.00	-1.712	-2.35*
	SD	06.11	07.96		

Notes: M= Mean, SD = Standard Deviation.

The Physical subscale showed significant improvements on the T scores, but not on the Mann-Whitney. Cognitive scores improved more for Unemployed than Employed. This improvement was a trend on the T scores, yet showed a significant improvement on the Mann-Whitney.

Unemployed subjects seem to have significantly improved on their physical scores according to the t-test, this was not reflected in the Mann-Whitney.

Unemployed subjects improved significantly more on the cognitive sub-scale according to the Mann-Whitney.

Subject's Gender

Analysis was run to determine if the variable of subject gender affected outcomes.

Table of Means and Standard Deviations for Clients' Gender

		Male (n=11)	Female (n=9)	Z	T
CRI Total	**M**	08.09	03.11	-.875	1.07
	SD	06.18	12.79		
Cognitive	**M**	07.90	06.44	-.114	.296
	SD	05.43	13.99		
Social	**M**	06.09	-1.11	-1.640	2.04†
	SD	06.10	09.61		
Emotional	**M**	06.45	02.44	-.726	.870
	SD	09.24	11.40		
Spiritual	**M**	05.45	00.33	-1.256	1.47
	SD	06.23	09.27		
Physical	**M**	04.81	03.00	-.573	.542
	SD	05.19	09.56		

Notes: M= Mean, SD = Standard Deviation.

There were no significant results for this set of analysis. Social scores improved more for Men than Women. (Trend, not significant).

Although it is reported that male subjects improved more than females on the mean, there was no significant difference found in relationship to the amount of improvement of the client from when they began therapy and at a three-month follow-up and the client's gender. This lack of significance holds true of the Coping Resources Inventory total scale and the five sub-scales.

There was a trend found that male clients improved more on a social scale than women. This trend was only found in the sub-scale of "social".

The mean for male scores on the "social" sub-scale in the first collection of data was 43 (n=18). The mean for female scores on the "social" sub-scale was 41 (n=18). This data reflects the trend that male subjects scored higher on the social sub-scale to begin with and improved more than women over the therapeutic intervention.

Subject Having Attended Therapy in the Past

Analysis was run to determine if there was a significant improvement for subjects that attended therapy in the past for the same presenting problem.

Table of Means and Standard Deviations for Previous Therapy

		Yes (n=10)	No (n=10)	Z	T
CRI Total	**M**	08.60	03.10	-.795	1.27
	SD	08.38	10.70		
Cognitive	**M**	10.60	03.90	-1.173	1.56
	SD	08.61	10.42		
Social	**M**	05.50	00.20	-.949	1.43
	SD	06.94	09.39		
Emotional	**M**	06.30	03.00	-.494	0.71
	SD	11.45	09.06		
Spiritual	**M**	04.50	01.80	-.417	0.74
	SD	07.16	08.86		
Physical	**M**	06.10	01.90	-1.445	1.31
	SD	05.04	08.82		

Notes: M= Mean, SD = Standard Deviation.

There were no significant results for this set of analysis.

This result suggests there is no significant difference between subjects who are attending therapy for the presenting problem for the first time and subjects who have attended therapy in the past.

Gender Mix of Therapist and Subject

Analysis was run to determine if the gender mix of therapist and subject influenced outcome to the subjects.

Table of Means and Standard Deviations for Gender Mix

		Same Sex (n=14)	Different Sex (n=6)	Z	T
CRI Total	**M**	07.71	01.50	-1.529	1.32
	SD	09.60	09.52		
Cognitive	**M**	09.00	03.16	-1.156	1.22
	SD	09.94	09.41		
Social	**M**	03.42	01.50	-.621	0.45
	SD	08.94	07.91		
Emotional	**M**	06.42	00.50	-.912	1.20
	SD	10.41	09.13		
Spiritual	**M**	04.85	-00.83	-1.075	1.51
	SD	06.88	09.53		
Physical	**M**	04.64	02.50	-.788	0.59
	SD	08.03	05.64		

Notes: M= Mean, SD = Standard Deviation.

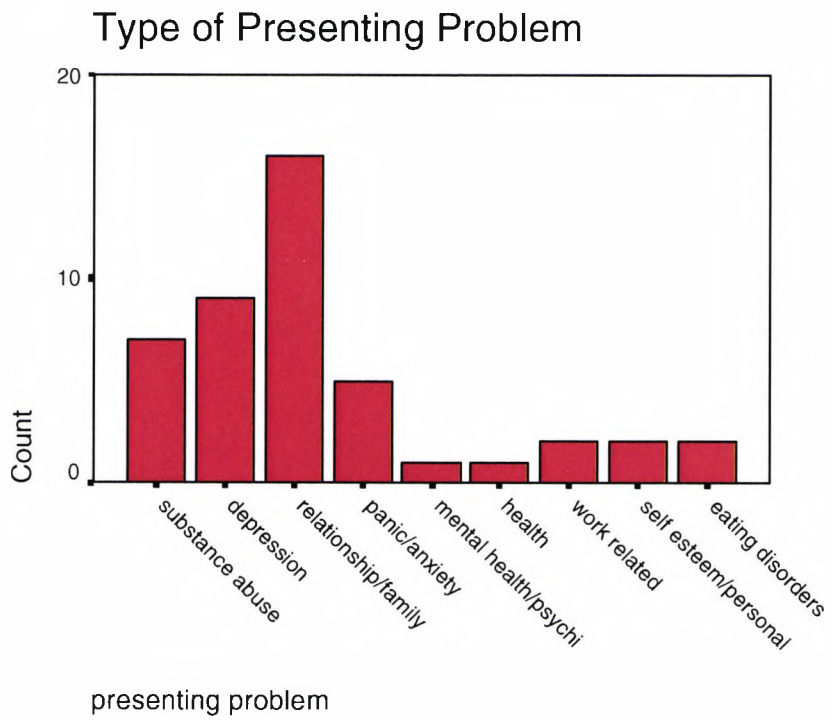
There were no significant results for this set of analysis.

This result suggests that there is no significant influence on the outcome of therapy and the mix of genders of subject and therapist.

Presenting Problem

There were nine different categories of problems that subjects presented to their therapist as the presenting problem. The nine categories were: substance abuse, depression, relationship/family, panic/anxiety, mental health/psychiatric, health, work related, self-esteem/personal, and eating disorders.

The graph below outlines the distribution of the types of presenting problem.



There were an insufficient number of subjects to establish difference across nine categories of presenting problems. Therefore the categories were collapsed into two categories: interpersonal and intrapersonal. Interpersonal problems were defined as problems that related to the client's relationship with others. Intrapersonal was defined as problems that relate to the client's relationship with self and internal problems. The problems were categorised as interpersonal: relationship/family and work related and intrapersonal: substance abuse, depression, panic/anxiety, mental health/psychiatric, health, self-esteem/personal, and eating disorders.

After the collapsing of the categories there were eight subjects classified as having interpersonal problems and 12 subjects that were classified as having intrapersonal problems.

Analysis was run to determine if the type of presenting problem, interpersonal or intrapersonal, affected the outcome of subjects.

Table of Means and Standard Deviations for Presenting Problem.

		Interpersonal (n=8)	Intrapersonal (n=12)	Z	T
CRI Total	**M**	-00.37	10.00	-2.203*	-2.67*
	SD	10.28	07.12		
Cognitive	**M**	03.12	10.00	-1.429	-1.57
	SD	12.71	06.83		
Social	**M**	-02.12	06.16	-1.937*	-2.39*
	SD	09.47	06.10		
Emotional	**M**	00.25	07.58	-1.164	-1.65
	SD	09.64	09.83		
Spiritual	**M**	-02.12	06.66	-2.474*	-2.87*
	SD	06.81	06.81		
Physical	**M**	-00.75	07.16	-2.367*	-2.74*
	SD	06.45	06.22		

Notes: M= Mean, SD = Standard Deviation.

There was a significant improvement of the total Coping Resources Inventory for intrapersonal problems. This significance was shown both in the t-test and the Mann-Whitney.

This significance was also shown in both the t-test and Mann-Whitney for the sub scales of social, spiritual, and physical.

It is suggested from this result that subjects improved significantly more when presenting with intrapersonal problems.

Change Across Time

ANOVA Table for changes in group means across time.

				ANOVA Effect		
Variable		**Time1**	**Time2**	**Time3**	**F**	**Difference in Means**
CRI Total	**M**	35.41	36.85	41.00	2.42†	T1=T2<T3
	SD	09.19	10.31	08.69		
CRI Cognitive	**M**	34.74	34.15	40.70	2.11	T1=T2=T3
	SD	11.52	13.08	09.58		
CRI Social	**M**	42.28	45.77	47.35	1.89	T1=T2=T3
	SD	10.31	10.76	08.46		
CRI Emotional	**M**	38.71	40.08	43.20	1.81	T1=T2=T3
	SD	08.15	08.66	09.19		
CRI Spiritual	**M**	37.13	34.69	38.05	0.63	T1=T2=T3
	SD	08.87	09.10	07.34		
CRI Physical	**M**	41.72	45.38	46.95	2.79†	T1=T2<T3
	SD	08.63	10.32	06.58		

Notes: M= Mean, SD = Standard Deviation.

There were no significant results for this set of analysis.

The Differences in Means for Total and Physical scores are different at the.10 level. This is a trend, not a significant difference. Bonferroni t-tests are not calculated, as there is no significant difference in means.

Length of Time in Therapy

Analysis was run to determine if the length of time in therapy influenced the subject's outcomes.

Table of Correlations between CRI scales and Length of Time in Therapy.

CRI Scales	Correlation
Total	.149
Cognitive	.079
Social	.211
Emotional	.124
Spiritual	.134
Physical	.098

†p<.10, * p<.05, ** p<.01, *** p<.001

There were no significant correlations for this set of analysis.

This suggests that there is no difference in outcome in relation to the amount of calendar time a client spent in therapy.

Number of Sessions

Analysis was run to determine if there was a correlation between the outcomes of subjects and the number of sessions they attended.

Table of Correlations between CRI scales and Number of Sessions in Therapy.

CRI Scales	Correlation
Total	.136
Cognitive	.038
Social	.108
Emotional	.101
Spiritual	.181
Physical	.196

†p<.10, * p<.05, ** p<.01, *** p<.001

There were no significant correlations for this set of analysis.

There was no significant difference or trend found in relationship to the amount of improvement of the client from when they began therapy till the three-month follow-up after the termination of therapy and the number of sessions attended (Mean number of sessions attended=2.67, Mode number of sessions attended =1).

Difference in Age Between Subject and Therapist

Analysis was run to establish if there was a correlation between subject's improvement and the age difference between the subject and the therapist.

Table of Correlations between CRI scales and Difference in Ages.

CRI Scales	Correlation
Total	-.051
Cognitive	-.042
Social	-.326
Emotional	-.006
Spiritual	.040
Physical	.270

†p<.10, * p<.05, ** p<.01, *** p<.001

There were no significant correlations for this set of analysis.

This result suggests there is no correlation between the level of subject's improvement and the difference between the therapist and subject's age.

Subject's Age

Analysis was run in relation to the correlation between the subject's age and the level of their improvement.

Table of Correlations between CRI scales and Clients' Age.

CRI Scales	Correlation
Total	-.181
Cognitive	-.264
Social	-.017
Emotional	-.065
Spiritual	-.206
Physical	-.336

†p<.10, * p<.05, ** p<.01, *** p<.001

There were no significant correlations for this set of analysis.

This result suggests that there is no correlation between the age of the subject and the amount of improvement.

Therapist's Age

Analysis was conducted to investigate the correlation between the therapist's age and the amount of improvement of the subjects.

Table of Correlations between CRI scales and Therapist's Age.

CRI Scales	Correlation
Total	-.191
Cognitive	-.337
Social	-.219
Emotional	-.038
Spiritual	-.082
Physical	-.195

†p<.10, * p<.05, ** p<.01, *** p<.001

There were no significant correlations for this set of analysis.

This result suggests that there is no correlation between the age of the therapist and the subject's improvement.

Therapist and Subject Perception Questionnaire

As Therapist and Client perceptions were rated on a scale of 1-10, a non-parametric Mann-Whitney test was used to investigate differences in ratings for the following items.

1. Is there a significant difference between Client Perception Questionnaire 1 and Therapist Perception Questionnaire 1?
2. Is there a significant difference between Client Perception Questionnaire 2 and Therapist Perception Questionnaire 2?
3. Is there a significant difference between Client Perception Questionnaire 3 and Therapist Perception Questionnaire 3?
4. Is there a significant difference between Client Perception Questionnaire 4 and Therapist Perception Questionnaire 4?
5. Is there a significant difference between Client Perception Questionnaire 5 and Therapist Perception Questionnaire 5?
6. Is there a significant difference between Client Perception Questionnaire 6 and Therapist Perception Questionnaire 6?
7. Is there a significant difference between Client Perception Questionnaire 7 and Therapist Perception Questionnaire 7?
8. Is there a significant difference between Client Perception Questionnaire 8 and Therapist Perception Questionnaire 8?
9. Is there a significant difference between Client Perception Questionnaire 9 and Therapist Perception Questionnaire 9?
10. Is there a significant difference between Client Perception Questionnaire 10 and Therapist Perception Questionnaire 10?
11. Is there a significant difference between Client Perception Questionnaire 11 and Therapist Perception Questionnaire 11?
12. Is there a significant difference between Client Perception Questionnaire 12 and Therapist Perception Questionnaire 12?

Table of Ranks for Client Therapist Perception Comparisons.

		Client (n=26)	Therapist (n=16)	Z
Question 1	**M**	22.77	19.44	-0.875
	SR	592.00	311.00	
Question 2	**M**	25.04	15.75	-2.404*
	SR	651.00	252.00	
Question 3	**M**	20.87	22.53	-0.432
	SR	542.50	360.50	
Question 4	**M**	23.60	18.09	-1.436
	SR	613.50	289.50	
Question 5	**M**	19.77	24.31	-1.180
	SR	514.00	389.00	
Question 6	**M**	22.77	19.44	-0.882
	SR	592.00	311.00	
Question 7	**M**	22.52	18.63	-1.035
	SR	563.00	298.00	
Question 8	**M**	19.63	21.81	-0.589
	SR	471.00	349.00	
Question 9	**M**	18.27	26.75	-2.194*
	SR	475.00	428.00	
Question 10	**M**	20.48	21.81	-0.355
	SR	512.00	349.00	
Question 11	**M**	22.19	20.38	-0.472
	SR	577.00	326.00	
Question 12	**M**	20.02	23.91	-1.023
	SR	520.50	382.50	

Notes: M= Mean Rank, SR = Sum of Ranks.

Clients rated Q2 as more important than the Therapists.
Therapists rated Q9 as more important than the Clients.

In the comparison of the Client Perception Questionnaire and the Therapist Perception Questionnaire, which was collected on the fourth session, if the subject attend for a fourth session, out of the twelve questions there were only two that showed a significant difference

between the subject's rating on a ten-point scale and the therapist's rating on a ten-point scale.

Questions Two: "How helpful was it to talk about the past?"

Subjects believed it was significantly more helpful to talk about the past during the fourth session than the therapist.

Question Nine: "How much of the time was spent talking about what you were already doing right?"

Therapists believed that a significantly more amount of time was spent talking about what the subject was already doing right than the subject's perception.

Three One-Way ANOVA's were conducted to investigate differences in standard CRI scores over each of the five sub-scales at each of the three testing occasions.

- If there is a significant difference between CRI 1 Scores: Cognitive, Social, Emotional, Spiritual, Physical
- If there is a significant difference between CRI 2 Scores: Cognitive, Social, Emotional, Spiritual, Physical
- If there is a significant difference between CRI 3 Scores: Cognitive, Social, Emotional, Spiritual, Physical

ANOVA Effect								
Time		Cognitive	Social	Emotional	Spiritual	Physical	F	Difference in
Time 1	M	34.73	42.28	38.71	37.12	41.71	4.22**	Co<So*,
	SD	11.51	10.30	08.14	08.87	08.63		Co<Ph*
Time 2	M	34.15	45.76	40.07	34.69	45.38	3.67**	Co<So*
	SD	13.08	10.76	08.65	09.10	10.32		
Time 3	M	40.70	47.35	43.20	38.05	46.95	4.64**	So>Sp*, Ph>Sp*
	SD	09.58	08.42	09.18	07.33	06.58		

ANOVA Table for differences in sub-scale means at each time.
Notes: M= Mean, SD = Standard Deviation.
†p<.10, * p<.05, ** p<.01, *** p<.001
Co= Cognitive
So= Social
Em= Emotional
Sp= Spiritual
Ph= Physical

In the first administration of the Coping Resources Inventory, before the beginning of counselling there were significant differences between some of the sub-scores: The Cognitive scores of subjects were significantly less than the Social and Physical scores. Subjects that arranged to attend therapy were functioning lower on a cognitive level than socially or physically.

The second administration of the Coping Resources Inventory was during the fourth counselling session, if the subject attended for a fourth counselling session. There was a significant difference between the subject's mean cognitive score and their social scale. Subjects rated significantly lower on their cognitive sub scale in relation to their social sub scale. There was also a trend in relation to subjects scoring lower on their cognitive and spiritual scores in relation to their physical scores on the fourth session. There was also a trend in relation to subjects scoring lower in their spiritual scores in relation to their social scores.

On the administration of the Coping Resources Inventory three months after the termination there was a significant difference in the scores of subjects. Subjects scored significantly higher on social sub-scales than spiritual sub-scale. Subjects also scored significantly higher on their physical as opposed to spiritual sub-scales. There was also a trend towards subjects scoring higher on their social sub-scale as opposed to their cognitive sub-scale.

Discussion

The outcomes presented in this paper show very little change in the progress of the clients between their first scores before beginning therapy and their three-month follow-up. In reviewing the literature of past research on the outcome of Solution Focused Brief Therapy, all the research shows significant improvement of clients owing to the therapeutic intervention. However, the majority of these studies are uncontrolled and rely on human judgment to measure successful outcomes. A factor that may contribute to the low levels of improvement shown in this study may be that the model is ineffective or needs to adhere to standardised techniques for there to be significant improvement. Another consideration regarding the low level of significant change is the small sample size and diversity of subjects. It is also possible that the Coping Resources Inventory (CRI) is not a valid instrument to measure improvement of therapeutic intervention. In review of the project presented it is difficult to ascertain if the low level of significant outcome is due to the effectiveness of the model, the sample size, or the validity of the Coping Resources Inventory (CRI).

Therefore it would be important to develop other standardised measures that reflect the ethos of the model for data collection. The Outcome Questionnaire (OQ 45) (Lambert et al., 1996a; Lambert & Burlingame, 1994; Lambert et al., 1996b; Lambert et al., 1996c; Lambert, Lunnen, Umphress, Hansen, & Burlingame, 1994) and the Clinical Outcomes in Routine Evaluation (CORE) (CORE, 1998) are

testing instruments that have become readily available since the development of this research project. It is felt that these newer instruments should be considered for future research projects into Solution Focused Brief Therapy. Both these instruments have been developed with questions that focus on the strengths and abilities of the subjects. In the past few years there have been numerous articles highlighting the use of the Outcome Questionnaire (OQ45) (Lambert et al., 1996a) (Lambert et al., 1996c) (Umphress et al., 1997) and the Clinical Outcomes in Routine Evaluation (CORE) (Howard, Lueger, & al, 1993) (Barkham & Evans, 1998), suggesting their effectiveness in measuring the outcome of therapeutic interventions with clients.

The Client Perception Questionnaire (Appendix 3) was developed for this research project to measure the different perceptions of the subjects in relation to how much time in the session they felt was spent talking about various topics and how helpful they found these conversations. The questions asked about the focus of the sessions on the past, present or future of the subject's life and techniques used in the session that would be considered solution focused techniques. This information was collected without the therapist seeing the subject's answers, in a sealed envelope provided to the subject.

The Therapist Perception Questionnaire (Appendix 4) was developed to measure the therapist's perceptions of how much time was spent during the session on different topics and techniques and

how helpful the therapist felt these were during the session. The intention was to compare and contrast the subject's and therapist's perception of the fourth session of therapy and if they differed in their perception of the helpfulness of various solution focused techniques.

These instruments were developed and piloted with ten subjects and therapists to determine if the instrument was clear and easily administered. After the pilot of the Client Perception Questionnaire and the Therapist Perception Questionnaire, there were no changes made to the instrument, as the reports regarding these instruments showed that it was clear and easily administered.

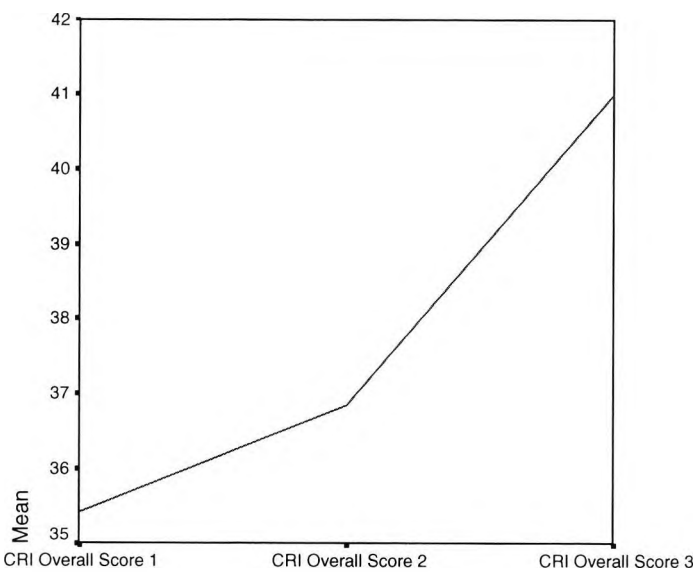
A drawback in relation to the Client Perception Questionnaire and the Therapist Perception Questionnaire is that these instruments are not standardised. Therefore the reliability and validity has not been established across other measures.

Although there were drawbacks to the design of the research project there are several interesting points that have developed from the analysis of the data. The first is the levels of improvement of subjects between first attending therapy, through their fourth session, and at a three-month follow-up. The hypothesis was that subjects' coping resources as measured on the Coping Resources Inventory would improve on the sub-scales and the total scale. The data analysis showed that there was no significant improvement for subjects on the Coping Resources Inventory. There were trends towards improvement on the total Coping Resources Inventory scale and the

physical sub-scale of the Coping Resources Inventory. Although there was no significant improvement and trends were only relative to the overall score and the physical scores, all scales showed improvement between the mean of the scores before the start of therapy and the three-month follow-up. For the most part this was seen as a steady increase of scores across time. The second score taken at the fourth session dipped for both the cognitive and spiritual sub-scales.

Graph 1

Comparison of overall Coping Resources Inventory across testing 1, 2 & 3

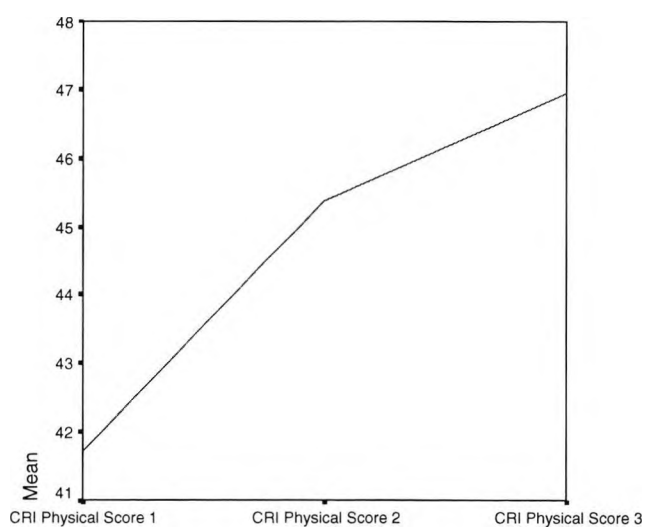


The mean scores of subjects improved across time, yet statistically this was a trend, not a significant improvement As discussed, some of the reasoning for this lack of significance could be

the fault of the instrument to measure the changes in the subjects owing to cultural biases or the validity of the instrument to measure change. Another conclusion could be that SFBT as a method of treatment was not a sufficient model to elicit change in a significant manner. However, this conclusion contradicts all the past research on this model of therapy (Beyebach et al., 1996; Beyebach et al., 1999; Burr, 1993; Cockburn et al., 1997; de Shazer, 1985; de Shazer, 1991; DeJong & Hopwood, 1996; Eakes et al., 1997; George, Iveson, & Ratner, 1990; Johnson & Shaha, 1996; LaFontain & Garner, 1996; Lambert, Okiishi, Finch, & Johnson, 1998; Lee et al., 1997; Lindforss & Magnusson, 1997; Macdonald, 1994; Macdonald, 1997).

Graph 2

Comparison of Coping Resources Inventory Physical Sub-scale across testing 1, 2, & 3

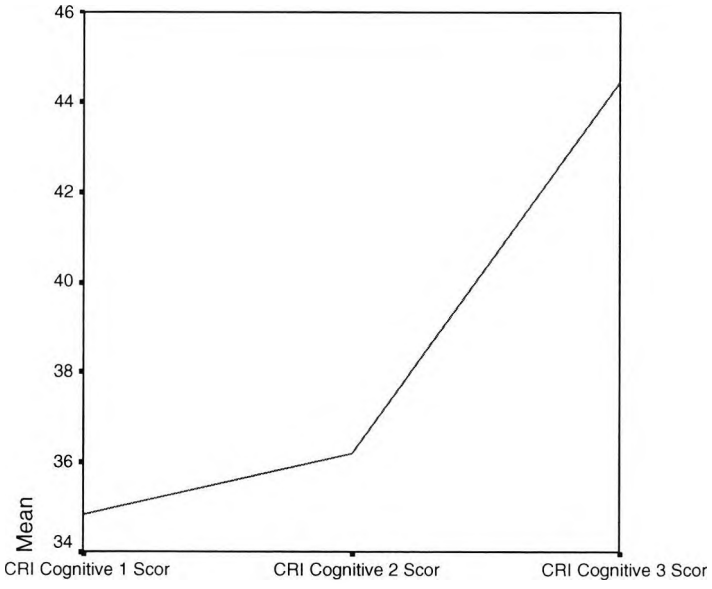


It is unclear why the overall Coping Resources Inventory score and the physical sub-scale showed trends towards improvement, whereas the other sub-scale (Cognitive, Social, Emotional, and Spiritual) did not show trends towards improvement. It can be suggested from this data that Solution Focused Brief Therapy has a greater influence on subjects' physical well-being than on other aspects of their life. The Coping Resources Inventory defines the sub scale of "physical" as:

> "The degree to which individuals enact health-prompting behaviours believed to contribute to increased physical well-being. Physical well-being is thought to decrease the level of negative responses to stress and to enable faster recovery. It may also help to attenuate potentially chronic stress-illness cycles resulting from negative physical responses to stressors that themselves become major stressors."

Graph 3

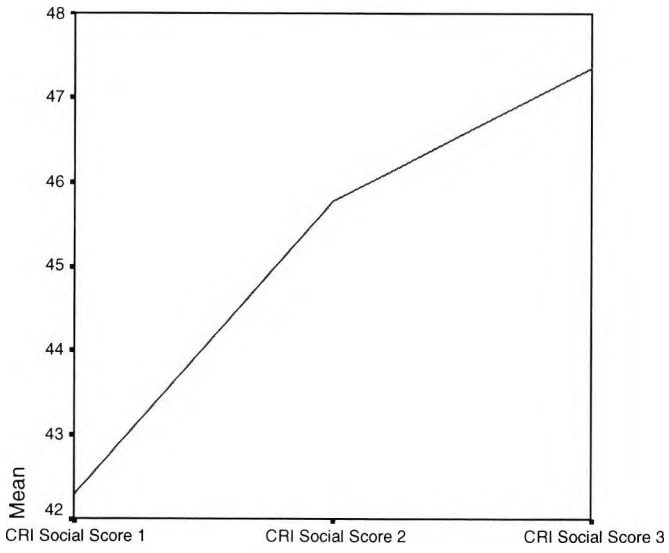
Comparison of Coping Resources Inventory Cognitive Sub-scale across testing 1, 2 & 3



Although there was no significant improvement or trend for subjects on the cognitive sub-scale, subjects did improve over time with a mean score of 34.74 on the first administration of the test before the therapy, a mean score of 34.15 on the second measure and a mean score of 40.70 on the three-month follow-up measure. It is unclear why the subjects dipped in their cognitive scores during the time of therapy. This could indicate a reduction of the subject's ability to "maintain a positive sense of self-worth, a positive outlook towards others, and optimism about life in general" (Hammer, 1988) during the time they were attending therapy.

Graph 4

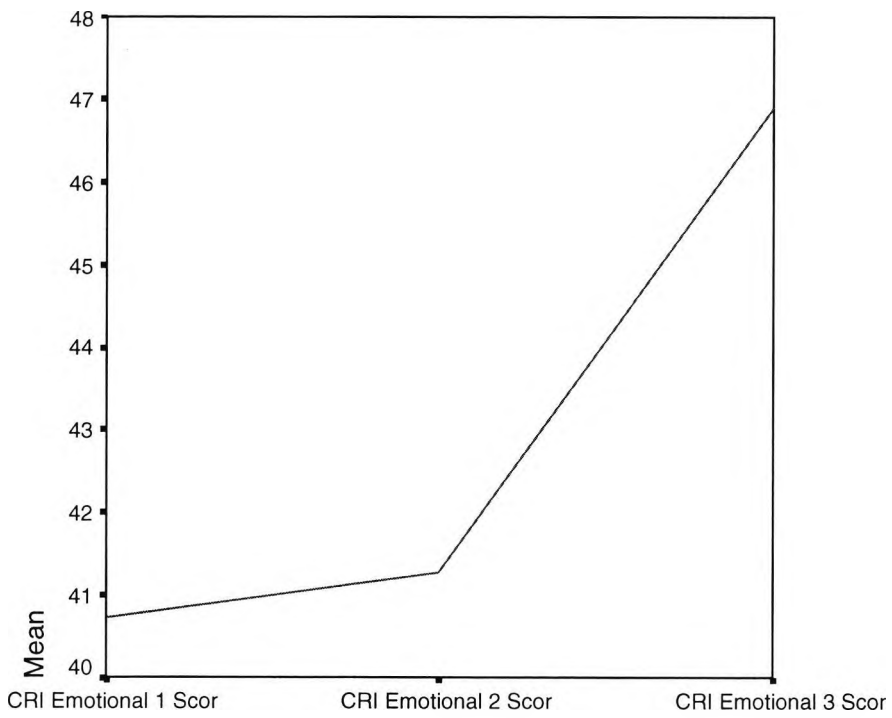
Comparison of Coping Resources Inventory Social Sub-scale across testing 1, 2 & 3



The mean of the subjects' social sub-scales improved over time from a mean of 42.28 before therapy began, to a score of 45.77 during therapy, and a three-month follow-up mean score of 47.35. Although this result is not statistically significant, it suggests that subjects improve in "the degree to which they are imbedded in social networks that are able to provide support in times of stress" (Hammer, 1988).

Graph 5

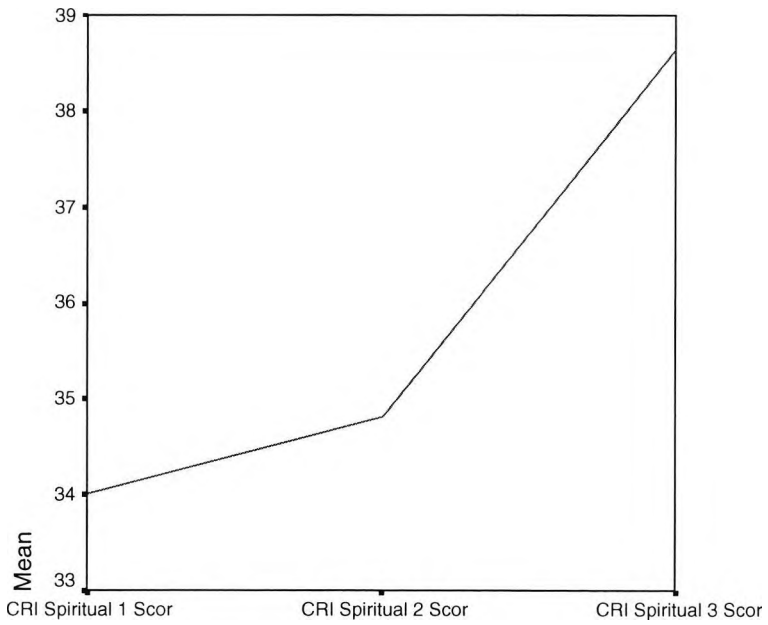
Comparison of Coping Resources Inventory Emotional Sub-scale across testing 1, 2 & 3



Subjects improved on their emotional sub-scale across time, with a mean of 38.71 before starting therapy, to a mean of 40.08 during the course of therapy, and ending with a mean score of 43.20 at a three-month follow-up. Although these results are not statistically significant they suggest that subjects improved over time in relation to being "able to accept and express a range of affect" (Hammer, 1988).

Graph 6

Comparison of Coping Resources Inventory Spiritual Sub-scale across testing 1, 2 & 3



The subjects' mean scores for the spiritual sub-scale improved between the scores taken before starting therapy with a mean of 37.13 and at the three-month follow-up with a mean of 38.05. The subjects' mean scores dipped to a mean of 34.69 during therapy. The reason for this drop in the scores during the therapeutic interventions is unclear. Although the mean scores improved between the first and third administration they were not statistically significant in their improvement. These results could suggest that the therapeutic intervention affected "individuals being guided by stable and consistent values derived from religious, familial, or cultural tradition or from personal philosophy" (Hammer, 1988).

Comparison of Variables

The data was analysed in relation to a range of variables including: client's age, gender, employment status, previous therapeutic intervention, and type of presenting problem. The data also investigated the variables in relation to the therapist's age, gender, level of training and whether the therapist worked within a therapeutic team or individually.

The results assert that there is no significant correlation or trend between the degree of the subject's improvement and the subject's age or gender. There also is no significant correlation or trend between the subject's improvement and the therapist's age and gender. The results of the data analysis for this research project are similar to the results of other studies measuring the correlation between outcome and age and gender of the client and therapist (DeJong & Hopwood, 1996). Historically the research has shown that there is not a significant difference in the outcomes of subjects in relation to their age or gender or the therapist's age or gender. From this data it is suggested that the age and/or gender of practitioners and clients working within the model of Solution Focused Brief Therapy does not influence the productiveness of the model.

The data analysis also illustrates that a mix of gender between client and therapist did not indicate any significant correlation or trend. Also a mix of age between client and therapist did not show any significant correlation or trend. This result mirrors the results in

previous research looking the correlation between the mix of gender and age of client and therapist (DeJong & Hopwood, 1996). The historical research implies that there is no difference in the outcome of subjects where there is a mix in the client's and therapist's age or gender. This suggests that the model of Solution Focused Brief Therapy is equally as effective when the client's and therapist's ages or gender differ.

There was not sufficient data to analyse the correlation between racial mix of client and therapist and effectiveness of the model across different races. All the therapists involved in the data collection were white and there were not a sufficient number of subjects from other race categories (there was only one Asian client and only one black client). However, the historical research suggests that there is no significant difference in outcome if the therapist's and client's races are mixed or if they are similar (DeJong & Hopwood, 1996).

The data in relation to the subject's socio-economic level as indicated by the subject's current employment status shows a significant improvement in the cognitive sub-scale (Mann-Whitney) and in the physical sub-scale (t-test) for subjects who are unemployed. The mean scores of subjects' first Coping Resources Inventory cognitive sub-scale between employed subjects (n=23) 35.7 and unemployed subjects (n=12) 35.4 are similar. The analysis shows that on the cognitive sub-scale unemployed subjects showed a significantly greater improvement than employed. The historical research shows

that there is little difference in the outcomes using indicators of socio-economic status (DeJong & Hopwood, 1996).

The research under discussion did not investigate the reason for the subject's unemployment. It is possible that some of the subjects who were unemployed were disabled or working at home as a housewife or househusband. There was not sufficient information gathered to infer the reason for the significance in the improvement for unemployed subjects on the cognitive and physical sub-scale of the Coping Resources Inventory.

Another variable that was analysed was whether the subjects had presented to therapy in the past with the same presenting problem for which they were currently seeking therapy. The data was analysed to assess if this influenced outcome. There was no significant correlation or trend in outcome between subjects who had sought therapy in the past for the same presenting problem and subjects who were presenting for the first time in relation to the presenting problem. It can be suggested that this model is equally as effective with presenting problems that have been addressed in the past and presenting problems that are being brought to therapy for the first time.

Another variable that was analysed was the level of subjects' improvement compared to the therapist's level of academic qualification. The therapist's level of training was divided into academic and non-academic categories to analyse if this variable affected subject's level of outcome. There was no significant correlation

or trend between the therapist's level of training and the subject's level of improvement. This result is similar to other results that show that "expert" therapists showed no better results than therapists in training (Beyebach et al., 1996), although some research suggests that student therapists needed three times the number of sessions to reach the final outcome attained by practised therapists (Lambert & Bergin, 1994). From the data analysis in this research it is suggested that therapists who were trained "on the job" or through reading and attending workshops had equivalent results in outcome to therapists who held an academic qualification to the level of Diploma or a Masters degree. This suggests that the model is equally as effective when used by professionals who have varying ranges of training and that to practice this model effectively, the professional does not have to obtain an academic qualification.

The consequence of therapists working in a team or independently was also examined. The therapeutic model was developed in a team setting and training in the model at the founders' practice is completed using team work (de Shazer et al., 1986). Although the original development of the model used a team of therapists, the practice of the model is often carried out using a single therapist. The results of this research project showed that there was no significant difference or trend between the outcome results of therapists working within a team and those working independently. This result parallels past research, which shows no difference between

teams and individuals (Burr, 1993). Research has led professionals to question the cost-effectiveness of working in a team.

It is suggested by the research that although the model of Solution Focused Brief Therapy was originally developed using a team format that it is equally as effective being used by an individual therapist. The technique of the therapeutic break during the session should still be implemented regardless whether the therapeutic break is with a team or an individual therapist. The shift in thinking seems to be that it is the therapeutic break that enhances change with clients, not the team of therapists. The use of the break and the feedback after the break has been explored in more recent publications, suggesting that the break should be more client-centred than the original model outlines (Sharry et al., in press). For example, Sharry (in press) suggests the break is set up to ask the client to take time out to think about what has been useful within the session and what the client feels would be the most helpful way to proceed.

The results analysis also examined whether the length of time the subject spent in therapy influenced the outcome. In the model of Solution Focused Brief Therapy the concept of length of time in therapy in terms of weeks, months, and years needs to be distinguished from the number of sessions attended. Owing to the fact that the client is the one who decides when they attend their next session, a therapeutic intervention that might be brief in number of sessions might be long in relation to a period of time. For example, a client who might only

attend for three sessions, might have attended these sessions over a year or longer.

The results analysed both the length of time subjects spent in therapy and the number of sessions attended to see if there was a correlation between these factors and outcome. The length of time subjects spent in therapy was divided into bands of time:

- One week (one session)
- One week to one month
- One to three months
- Three to six months
- Six months to a year
- One year to eighteen months
- Over eighteen months

In the data, 48% (n=19) of subjects finished their therapeutic intervention within one week. This meant that they only attended for one session, which would be consistent with most therapeutic intervention (Talmon, 1990). The data showed that 12% (n=5) finished within one week and one month and 27% (n=11) finished therapy within one to three months. In fact only 2% of the subjects (n=1) were still attending therapy after one year. This corresponds with 85% of subjects completing their therapeutic intervention within three months of starting therapy.

The results showed no significant correlation or trend between the length of time subjects stayed in therapy and their outcome. Even

when the bands of time were collapsed to two categories: 1) subjects that attended for one week and 2) subjects that attended for more than one week, there was no significant difference between the two groups. It can be suggested that subjects respond equally well to the solution focused model of therapy regardless of the amount of time across the calendar that they attend therapeutic sessions.

The data analysis also looked at the number of sessions attended by subjects compared to their level of outcome. The range of sessions attended was between one and seven sessions. The mode number (n=19) of times that clients attended was 1 and the mean number of sessions attended was 2.67. There was a clustering of subjects who attended four sessions (n=8), which would relate to past data in terms of number of sessions attended (Burr, 1993; de Shazer, 1985; de Shazer, 1991b; McKeel, 1996; Metcalf & Thomas, 1994; Miller, 1994). The results show that 81% (N=34) of subjects completed therapy after four sessions.

There was no significant correlation or trend between the number of sessions attended by the subjects and their outcome in this research. When the data was collapsed into two categories of 1) subjects who attend one session and 2) subjects who attended more than one session, there was no significant difference between the two categories. There is some existing research to suggest that the number of sessions attended does relate to success rates. Burr's research (Burr, 1993) suggests that the most unsuccessful cases stopped after

two sessions. There is also research to suggest that clients who attend four or more sessions did significantly better than clients who attended for fewer than four sessions (DeJong & Hopwood, 1996). McKeel's (1996) research suggests that attending fewer than three sessions is significant to having lower success rates. This research also points out the there seems to be significant improvement for clients up to the eighth session and then progress is less likely (McKeel, 1996). Although the research presented in this paper shows there are no significant correlation or trend in relation to the number of sessions attended and the level of outcome improvement, there seems to be sufficient existing research to dispute this suggestion. Historical research suggests that the optimum number of sessions for clients is between three and eight sessions. There would need to be further investigation into these findings to suggest conclusions.

Another aspect of the data that was analysed was the comparison between the Client Perception Questionnaire (Appendix 3) and the Therapist Perception Questionnaire (Appendix 4). There were twelve questions that were administered to subjects at the fourth session of therapy and the therapist was to answer twelve corresponding questions. The therapist did not see the subject's answers and the subject did not see the therapist's answers. Of the twelve correlating questions, two showed a significant level of difference. Although the mean of all twelve questions reflected differences in client and therapist perception, it is interesting to

consider the questions that showed significant difference between the perception of the client and therapist.

Question 2) How helpful was it to talk about the past?

Subjects rated this question as significantly more important than the therapists did. This suggests that subjects found it more helpful to talk about the past during the therapeutic session, whereas therapists did not think it was as helpful for subjects to discuss the past.

Question 9) How much of the time was spent talking about what you were already doing right?

This question was developed to assess how much time the client and therapist felt they spent talking about "exceptions" to the problem, when the client was able to manage and cope with the situation. This question was rated significantly higher by therapists than by subjects. This suggests that therapists thought that significantly more time was spent during the session talking about exceptions to the problem. This result could be influenced by therapist bias. The model of Solution Focused Brief Therapy is based on the principle that it is more helpful for clients to develop in conversation what they do that helps them move away from the problem. It would be an objective of the solution focused therapist to have these types of conversation, therefore it is not surprising that the therapists rate clients higher on time spent having conversations about what the client is already doing right.

In the main the client and therapist did not significantly differ in their perception of the process of the therapy. In reflection it is understandable that there was differing perceptions in relation to the questions that did show significant difference. That clients felt it was significantly more helpful to talk about the past and problems than therapists.

Although this research project shows that only two out of twelve questions in relation to the perceived process of therapy are significantly different between the client and therapist, historical research shows that therapists and clients diverge greatly in their perceptions of the therapeutic process (McLeod, 1994; Metcalf & Thomas, 1994; Metcalf, Thomas, Duncan, Miller, & Hubble, 1996; Mintz, Auerbach, Luborsky, & Johnson, 1973).

Metcalf and her colleagues have specifically researched client and therapist perceptions in relation to Solution Focused Brief Therapy, as practised by the originating team in Milwaukee, Wisconsin, at the Brief Family Therapy Centre (BFTC). Their research suggests there are differences in perception between therapist and client. Although in all cases of Metcalf's research both client and therapist rated the therapeutic intervention "successful", there was a difference in the perception of interventions within sessions. Therapists believed they were theoretically correct and did not make active suggestions to the clients, while clients perceived active suggestions were being made. Also, therapists described the termination as collaborative, whereas the

client felt it was less mutual and at times felt "pushed out". Overall, therapists rated the techniques as effective, whereas clients felt it was the relationship factors that had the greatest impact (Metcalf & Thomas, 1994; Metcalf et al., 1996).

Metcalf's research reflects the data presented in this paper, highlighting that the subject's perception of the techniques and process of therapy differs from the therapist. From the data presented in this paper it is suggested that subjects perceive it to be more helpful to talk about their past than their therapist. Therapists' perceptions of how helpful it is to talk about the past may be influenced by the ideology of the solution focused model, which suggests that it is more helpful to develop a clear future with clients than it is to review the past. Therapists also thought that more time was spent talking about what the subject was already doing right, than the subjects did. This also reflects the ideology of the model, that the therapeutic session would be used to talk about what is already going right for the client, termed exceptions, and to build strengths, skills, and resources.

Although the model of Solution Focused Brief Therapy is based on the idea that the client is the expert on their life and the changes that could be made to bring about a more meaningful life, this research highlights the reality of the practice of therapy. Clients felt that talking about past, painful, or problematic events were helpful. They perceive themselves to be doing just this within the therapeutic environment. The therapists involved in this study responded as was expected: they

felt that time would be better spent developing a preferred future and that it is more helpful to talk about the exceptions to the problem. Perhaps solution focused therapists, although claiming to allow clients to take the lead, actually guide the client towards what the therapist perceive to be the most helpful conversations.

The Client Perception Questionnaire and the Therapist Perception Questionnaire were developed to reflect the solution focused model of therapy, using a similar style to the scaling question. Therefore the design of the perception questionnaires asked the participant to rate on a scale of one to ten. In retrospect, it would have been more statistically helpful to ask the participants to rate the questions within a smaller numerical range. It was more difficult to show significance using the ten-point scale within these questionnaires. This ten-point scale may have contributed to the fact that more significant difference was not highlighted between the Client and Therapist Perception Questionnaire.

A similar situation occurred in the collection of data in relation to the presenting problem. In the initial collection of data, there were nine categories of presenting problem into which the client could be classified: substance abuse; depression; relationship/family; panic/anxiety; mental health/psychiatric; health; work-related; self esteem/personal and eating disorders. During the analysis of data there were not enough subjects to consider the effect on outcome across nine categories of presenting problem. The categories of

presenting problems were further collapsed into two categories: interpersonal and intrapersonal.

Interpersonal was defined as problems that related to the subject's relationship with other people. The categories of relationship/family and work-related were collapsed into this category. Intrapersonal was defined as problems that related to the individual. The presenting problems of substance abuse, depression, panic/anxiety, mental health/psychiatric, health, self esteem, and eating disorders were assigned to the intrapersonal category.

There was significant difference in the data for interpersonal and intrapersonal. Subjects presenting with intrapersonal problems, problems that had to do with themselves, had significantly better outcome in the overall Coping Resources Inventory score, and the social, spiritual, and physical sub-scales. It is suggested from this data that the model of Solution Focused Brief Therapy has significantly better results with subjects presenting with problems that relate to themselves rather than to their relationships with others in their life. This result reflects the research conducted at the University of Salamanca, Spain. This research was conducted at the family therapy centre and suggests that the outcomes for personal complaints responded better to the solution focused model than relational complaints (Beyebach et al., 1996).

The results also showed significance for the different sub-scales across time. The Coping Resources Inventory showed that at

the time of presenting to therapy, subjects were functioning better socially and physically than cognitively. At the time of the second measure of the Coping Resources Inventory, subjects were scoring significantly higher on the social sub-scale than the cognitive sub-scale. At the three-month follow-up subjects scored significantly higher on the social and physical sub-scale than on the spiritual sub-score.

In reviewing this research project there has been some difficulties in the research protocol, some interesting results generated and ideas developed regarding future research development. In the consideration of the research project it is important to discuss the design and procedure of data collection. One major drawback of the research design was the fact that there was no control group or group offering another type of treatment (for example cognitive behavioural therapy). Owing to the fact that there was no control group it will be difficult to distinguish if any changes in the data are changes that would have occurred over time without the therapeutic intervention.

The lack of a second treatment group using a different model of therapy would also make it difficult to distinguish if it was the implementation of Solution Focused Brief Therapy that created the change or if the changes would have occurred as a result of any type of therapeutic intervention. Historical research (Lambert, 1992) suggests that the factors which create change in therapy are 40% client factors, 30% relationship factors between client and therapist, 15% placebo effect (the fact that clients believe things will change),

and that only 15% of therapeutic change is as a result of the techniques or model of therapy. Therefore, the change that is shown in the data may be attributed to the therapeutic effect of counselling and not specifically the model of Solution Focused Brief Therapy.

Another factor affecting data collection was the lack of control of the therapeutic intervention. The counselling sessions were not recorded or monitored to ensure that the therapists involved in the study were applying the model of Solution Focused Brief Therapy in a systematic way. The only criteria set out by the therapists were that they perceived themselves to be working in the model of Solution Focused Brief Therapy. All therapists that participated in the research considered themselves solution focused therapists, and the majority reported they were actively engaging in the solution focused techniques as described by the founders of the model. There could have been tighter measures applied to ensure that the therapists were practising the same techniques and using the same solution focused interventions, via use of audio or video recording of sessions. This level of monitoring the collection of data was unrealistic for this research project, but should be considered for future investigation into the model.

The design procedure also fell short of the stipulations recently set out by de Shazer and Berg (de Shazer & Berg, 1997) into what would constitute calling a therapeutic intervention Solution Focused

Brief Therapy in research. They specified that four specific techniques needed to be present:

1) Miracle Question
2) Scaling Question
3) Therapeutic Break in Session
4) Homework Task

In the European Brief Therapy Association meeting in Bruges 1999 (EBTA, 1999) the committee defined the criteria for Solution Focused Brief Therapy in research. They suggest that therapeutic intervention must include: goal questions, exception questions, questions in relation to pre-session change, questions elaborating on the client's resources, the miracle question, scaling questions, compliments to the client, and tasks. The committee also specify that return visits must begin with "What is better?" or a similar question.

These specific regulations in relation to the publication of research of Solution Focused Brief Therapy were published after the start of the collection of data for this research project. When the stipulations were published the research investigated the level to which the participating therapists met the requirements. The therapists in the research were asked about their implementation of the model during sessions on four accounts:

1) Miracle Question
2) Scaling Question
3) Therapeutic Break in Session

4) Homework Task

Only 63% of the participating therapists responded to the particular questionnaire, which asked them specifically about their normal practice in relation to the therapeutic interventions outlined above. Of the therapists that responded, 80% of these stated that they used the miracle question at some point during their interview, 10% said that they used the miracle question in 90-95% of their cases, and 10% said that they used the miracle question in 75-80% of the cases.

In response to the question regarding the use of scaling in their sessions 80% stated they used the scales 100% of the time, while 10% stated they used scales 95% of the time, and 10% responded they used scales 80-90% of the time. In relation to whether the therapist took a break during the therapeutic session 80% stated "yes" or "almost always", where 20% reported a more sporadic use of the break in their clinical work. In relation to the use of therapeutic tasks 90% of therapists responded "yes", where 10% responded, "compliments always – tasks rarely".

It is clear from the information presented above that various levels of the therapeutic techniques were involved in the practice of Solution Focused Brief Therapy in the therapeutic sessions. All the therapists who were used to collect data "perceived" themselves to be practising in the model of Solution Focused Brief Therapy and believed in the assumptions of the model: that it was more important to focus on the future rather than the past and on what was going right in the

subject's life, instead of what was going wrong. These therapists were committed to the overall ethos of the solution focused model and to the belief that short-term therapeutic interventions can be useful, yet they varied on their use of specific therapeutic interventions. Therefore, it would be hard to distinguish whether the results in the data were caused by therapeutic intervention in general, and unrelated to the model or the specific model of Solution Focused Brief Therapy.

There were also several issues in relation to the collection of data that created a small sample size. The research design was that data was collected for clients over eighteen years of age presenting for individual therapy to the various counselling agencies. Owing to the fact that historically the model of Solution Focused Brief Therapy grew out of a family therapy background, many of the cases presenting to the various counselling agencies were for couple or family counselling. These cases had to be discounted from the research project; therefore it took a long time to collect a significant number of subjects attending for individual sessions for the research project.

Another problem was the high dropout rate in the research after subjects initially agreed to take part in the project. Forty-five subjects agreed to participate in the research project and were administered the Coping Resources Inventory before they began therapy. Of these forty-five subjects, thirty-seven actually filled in and returned their Coping Resources Inventory. Of these thirty-seven only thirteen (35%) attended the fourth session of therapy, where the second

Coping Resources Inventory and the Client Perception and Therapist Perception Questionnaires was administered. This high dropout rate is surprising, highlighting that the average number of sessions attended was 2.67 and the mode number of sessions attended was 1. This trend of the majority of clients attending therapy for only one session is consistent with the data on therapy in general (Talmon, 1990).

However, the reason the fourth session was set as the second data collecting point was that past research has shown that on average clients in therapy across all models of therapeutic work including brief therapy models stay until the fourth session, if they continue after the first (Burr, 1993; de Shazer, 1985; de Shazer, 1991; McKeel, 1996; Metcalf & Thomas, 1994; Miller, 1994). Although there was a high rate of subjects ending therapy before the fourth session, there were no subjects who attended the fourth session and did not wish to participate in the research. The high level of dropout in the research is contributed to the low level of subject attendance at the fourth session, and not to non-participation in the research.

The three-month follow-up Coping Resources Inventory was filled in and returned by twenty subjects (54% of the subjects who participated in the research). It was possible for subjects who did not attend that fourth session to return the follow-up Coping Resources Inventory, because it was sent out in the post three months after the last sessions was attend. Therefore, even if the subject only attended

for one session, they were mailed the follow-up Coping Resources Inventory and asked to return it by post.

Other research projects cited in this paper have a higher level of follow-up feedback, but their data was collected from a phone call directly to the client (Beyebach et al., 1999; de Shazer, 1985; de Shazer, 1991; DeJong & Hopwood, 1996; George et al., 1990; Lee, 1997). It was felt in this research project that using a phone call to assess the subject's perceptions of their success was too subjective. This is why the design of a standardised instrument - the Coping Resources Inventory - was used to measure the subject's perceived coping skills.

Three months after subjects had finished with their therapy the Coping Resources Inventory had to be mailed to the thirty-seven subjects who participated in the research project. Of the thirty-seven subjects, twenty returned the follow-up Coping Resources Inventory, a 54% return rate. Beyebach states (Beyebach et al., 1996) that most research studies have a dropout rate of about 25% and that some are affected by more than 60% of the subjects dropping out. The research being presented in this paper is on the higher end of this dropout rate, with 46% of subjects dropping out of the research after the first measurement was administered.

This low level of data return on the second and third administration of the Coping Resources Inventory made the analysis of the data more difficult. Larger sample sizes would be necessary to

establish statistically significant levels of change in the subject's coping resources. This is especially true where such changes using the Coping Resources Inventory are historically small.

Another issue that caused difficulty in the research was the choice of instruments to collect the data. The three instruments used to collect data were 1) Coping Resources Inventory, 2) the Client Perception Questionnaire and 3) Therapist Perception Questionnaire. As pointed out earlier, other measures were considered for the collection of data in relation to the improvement of coping over the course of therapy and at a three-month follow-up. These other instruments were not chosen because they did not fit with the ethos of the solution focused model. The Beck Depression Inventory (Beck, 1978) and the General Health Questionnaire (Goldberg, 1981) were considered, but deemed too pathological in their questions. It was felt it would be better to use an instrument that would develop the subject's own sense of self worth in the questions. This reflection of the model was deemed more important than high levels of validity and reliability in the instrument. The Coping Resources Inventory was thought to be the most appropriate, however there were some problems with the use of the Coping Resources Inventory. One of the problems with the test was that it was not culturally aware of the British population. For example, a scantron (computer scored) form was used with the instructions:

Use a soft (no.2), black lead pencil. Mark dark, heavy marks that fill the bubble.

Many of the subjects commented that they did not know what a "no. 2" pencil was nor were they familiar with the method of filling in the scantron (computer scored) form. The use of this type of form is common in the United States and subjects from the United States would find this manner of data collection commonplace. Unfortunately, it was a source of confusion for the British subjects. To reduce confusion the subjects were provided with a pencil at each administration of the instrument.

Other subjects commented on the "American" tone to the statements and questions asked, for example:

I eat junk food

This question was phrased in American slang and some subjects may have found this confusing or unclear.

Although there were concerns about the design protocol, the research presented in this paper highlights some interesting findings in relation to the model of Solution Focused Brief Therapy. Unfortunately, the research did not produce significantly relevant data to determine the effectiveness of the model in general. Although the subjects in the research project improved over time in relation to their scores on the Coping Resources Inventory, these changes were not statistically relevant to suggest the models' usefulness. The results presented in this paper conflict with the results of past outcome research into the

model of Solution Focused Brief Therapy which suggest that the model is effective, although none of these past research projects used the Coping Resources Inventory. There are several contributing factors that may have affected the outcome of this project. The Coping Resources Inventory and the cultural problems highlighted earlier might have influenced the collection of data. There are also questions as to the validity of the Coping Resources Inventory in relation to the data collection. Does the Coping Resources Inventory sufficiently measure change in subjects? Also the low levels of subjects attending the fourth session created a low sample size in the project.

Of the data that was analysed there were three aspects of the data that gave significant results: 1) unemployed subjects improved more than employed subjects, 2) subjects with intrapersonal presenting problems (problems dealing with self) improved more than subjects with relational problems, and 3) subjects and therapists disagreed regarding how helpful it was to talk about the past and the problem during therapy.

It is suggested that there would need to be more research into the model of Solution Focused Brief Therapy to conclude the model's usefulness in the therapeutic world. It is recommended that more research is conducted that uses standardised instruments, like the Outcomes Questionnaire (OQ45) (Lambert et al., 1996b) (Lambert et al., 1994) and the Clinical Outcomes in Routine Evaluation (CORE) (Barkham & Evans, 1998) (CORE, 1998). In future research, therapy

sessions should be video or audio taped and monitored to ensure that the various components of the model outlined by the European Brief Therapy Association (EBTA, 1999) are in practice in the sessions.

In the development of future research it is also suggested that a control group or differing treatment groups be used to compare the levels of improvement. Although there have been several outcome studies in the model that highlight the improvement of subjects, few of these research projects used objective, standardised measures that could be compared to other research. There is also a lack of control groups in this and past research projects. The fact that these past research projects report healthy levels of improvement by clients is not dismissed, with 91% of clients achieving their goal (McKeel, 1996), 77% of clients improving (Burr, 1993), 70% of clients improving (Macdonald, 1994), and 74% of clients improving (DeJong & Hopwood, 1996) to name a few. However, it is not until these levels of improvement can be shown using research guidelines that define the model and ensure the parameters of the model are happening in the session, and that "improvement" is measured with standardised instruments that the model of SFBT can be classified as an effective model of change. In addition, future research should ensure the SFBT model be compared to a control group or other treatment group. Then the model can clearly be labelled as effective. This paper suggests that professionals, who are practising Solution Focused Brief Therapy and indeed any model of therapeutic intervention, work towards producing

research that will address the questions that this paper was unable to conclude.

In conclusion, the data presented in this paper was not able to establish the usefulness of the model of Solution Focused Brief Therapy. This may be owing to the ineffectiveness of the model or the invalid use of the Coping Resources Inventory. The research was not able to distinguish which of these is the reason for the lack of significant change in the subjects. Past research has suggested the effectiveness of the model of Solution Focused Brief Therapy, leaving the validity of the Coping Resources Inventory in question. To be able to report more solid, statistically based findings, further research would have to be produced to support the use of the solution focused model. This research also highlights the differing perceptions of the client and therapist during the therapeutic interventions. In the data collected for this paper it is suggested that clients felt talking about the past was more helpful than the therapists did. It is understandable that solution focused therapists would not focus on developing the problem or the history of the problem as this is in conflict with the ethos of the model. Yet clients still felt that talking about the past was helpful.

It is interesting to reflect on Lambert's research (Lambert, 1992), which highlights that only a small percentage - 15% - of therapeutic change is accounted for by the techniques of therapy. Lambert's research suggests that 40% of change is as a result of extra therapeutic factors that relate to the clients themselves, 15% is as a

result of relationship factors between the client and therapist, and 15% of therapeutic change is accounted for in a placebo effect, the client's belief that simply coming for help will indeed help. Perhaps it is more valuable to develop these client factors, relationships and belief that change is possible, than it is to focus on techniques in the therapeutic interventions.

Appendix 1

Client Code_____

Release Form
Solution Focused Brief Therapy Research

Will you consider helping us; a student at City University is carrying out research into Solution Focused Brief Therapy. This Research will be looking at the usefulness of brief therapy and hopes to improve the practice for all clients.

Participation in this research is not mandatory and non-participation will not affect your therapy in any way. You are under no obligation to participate. You are able to withdraw from this research at any point and this will not affect your therapy.

All research and therapists working on this project are covered by indemnity insurance to protect clients.

If you do choose to participate you will be asked to fill in a measurement called the Coping Resources Inventory before you begin therapy. This is a measurement of your coping resources at the time. This should take no longer than ten minutes.

If you do schedule a fourth appointment you will be asked to fill in a form regarding aspects of the sessions. This should take you no longer than five minutes. You will fill this form in on your own and will be provided with an envelope to seal the form in before giving it to your therapist. At no time during the research will your therapist be able to see your comments. At this time you will also be asked to fill in the Coping Resources Inventory again.

Three months after conclusion of therapy or at a date three months after your last appointment you will be sent a copy of the Coping Resources Inventory, a form asking if you met your goals of therapy, and a self addressed stamped envelope to mail the results back to City University.

In no way will your name or specific details to reveal your identity be used, for this reason you are asked not to put your name on the forms. This information will be used to establish research into what is working within the therapeutic process.

If at any point during the research you feel you are being negatively affected or would like to be informed of the results of this research you can discuss the issue with your therapist.

We thank you for your time and effort.

I agree to participate in the research mentioned above:

_____ _____

Date PRINTED NAME

_____

SIGNATURE

Address _____

_____

_____

Coping Resources Inventory – Form D

Allen L. Hammer, Ph.D. and M. Susan Marting

Directions

For each of the sixty statements that follow, fill in the circle on your answer sheet that best describes you in the last six months. For each statement mark one of the following descriptions:

Never or rarely
Sometimes
Often
Always or almost always

Do not make any marks in this booklet. Mark all of your answers on the separate answer sheet. It is important that you try to answer every question.

Consulting Psychologists Press
3803 E. Bayshore Road
Palo Alto, California 94303

3165

N = Never or rarely
S = Sometimes
O = Often
A = Always or almost always

1. I have plenty of energy.
2. I say what I need or want without making excuses or dropping hints.
3. I like myself.
4. I am comfortable with the number of friends I have.
5. I eat junk food.
6. I feel as worthwhile as anyone else.
7. I am happy.
8. I am comfortable talking to strangers.
9. I am part of a group, other than my family, that cares about me.
10. I accept the mysteries of life and death.
11. I see myself as lovable.
12. I actively look for the positive side of people and situations.
13. I exercise vigorously 3-4 times a week.
14. I accept compliments easily.
15. I show others when I care about them.
16. I believe that people are willing to have me talk about my feelings.
17. I can show it when I am sad.
18. I am aware of my good qualities.
19. I express my feelings to close friends.
20. I can make sense out of my world.
21. My weight is within 5 lbs. of what it should be.
22. I believe in a power greater than myself.
23. I actively pursue happiness.
24. I can tell other people when I am hurt.
25. I encourage others to talk about their feelings.
26. I like my body.
27. I initiate contact with people.
28. I confide in my friends.
29. I can cry when sad.
30. I want to be of service to others.

N = Never or rarely
S = Sometimes
O = Often
A = Always or almost always

31. I can say what I need or want without putting others down.
32. I accept problems that I cannot change.
33. I know what is important in life.
34. I admit when I'm afraid of something.
35. I enjoy being with people.
36. I am tired.
37. I express my feelings clearly and directly.
38. Certain traditions play an important part in my life.
39. I express my feelings of joy.
40. I can identify my emotions.
41. I attend church or religious meetings.
42. I do stretching exercises.
43. I eat well-balanced meals.
44. I pray or meditate.
45. I accept my feelings of anger.
46. I seek to grow spiritually.
47. I can express my feelings of anger.
48. My values and beliefs help me to meet daily challenges.
49. I put myself down.
50. I get along well with others.
51. I snack between meals.
52. I take time to reflect on my life.
53. Other people like me.
54. I laugh wholeheartedly.
55. I am optimistic about my future.
56. I get enough sleep.
57. My emotional life is stable.
58. I feel that no one cares about me.
59. I am shy.
60. I am in good physical shape.

Appendix 3

Client Perception Questionnaire

Client Code_____

Session Number_____

Date_____

Could you please take five minutes to fill in this form regarding your therapy session? Please circle the most appropriate answer. Do not put your name on the form, as it is anonymous. When you are finished put the form in the envelope provided. Seal the envelope and return it to your therapist. At no time during the research will your therapist be able to see your comments.

1. How much time in the session was spent talking about the past?

No Time The Whole Session

1 2 3 4 5 6 7 8 9 10

2. How helpful was it to talk about the past?

Not Helpful Very Helpful

1 2 3 4 5 6 7 8 9 10

3. How much of the time in the session was spent talking about the present?

No Time The Whole Session

1 2 3 4 5 6 7 8 9 10

4. How helpful was it to talk about the present?

Not Helpful Very Helpful

1 2 3 4 5 6 7 8 9 10

5. How much of the time in the session was spent talking about the future?

No Time The Whole Session

1 2 3 4 5 6 7 8 9 10

6. How helpful was it to talk about the future?

Not Helpful Very Helpful

1 2 3 4 5 6 7 8 9 10

7. How much time was spent talking about where you were from 0-10?

No Time The Whole Session

1 2 3 4 5 6 7 8 9 10

8. How helpful was it to talk about where you were from 0-10?

Not Helpful Very Helpful

1 2 3 4 5 6 7 8 9 10

9. How much of the time was spent talking about what you were already doing right?

No Time The Whole Session

1 2 3 4 5 6 7 8 9 10

10. How helpful was it to highlight what you were already doing right?

Not Helpful Very Helpful

1 2 3 4 5 6 7 8 9 10

11. How much of the time was spent talking about how you would like life to be?

No Time The Whole Session

1 2 3 4 5 6 7 8 9 10

12. How helpful was it to talk about how you would like life to be?

No Time The Whole Session

1 2 3 4 5 6 7 8 9 10

Appendix 4

Therapist Perception Questionnaire

Client Code_____

Session Number_____

Date_____

Please circle the most appropriate answer to the questions below.

1. How much time in the session was spent talking about the past?

No Time The Whole Session

1 2 3 4 5 6 7 8 9 10

2. How helpful to the client was it to talk about the past?

Not Helpful Very Helpful

1 2 3 4 5 6 7 8 9 10

3. How much of the time in the session was spent talking about the present?

No Time The Whole Session

1 2 3 4 5 6 7 8 9 10

4. How helpful to the client was it to talk about the present?

Not Helpful Very Helpful

1 2 3 4 5 6 7 8 9 10

5. How much of the time in the session was spent talking about the future?

No Time The Whole Session

1 2 3 4 5 6 7 8 9 10

6. How helpful to the client was it to talk about the future?

Not Helpful Very Helpful

1 2 3 4 5 6 7 8 9 10

7. How much time was spent talking about where the client was from 0-10?

No Time The Whole Session

1 2 3 4 5 6 7 8 9 10

8. How helpful to the client was it to talk about where they were from 0-10?

Not Helpful Very Helpful

1 2 3 4 5 6 7 8 9 10

9. How much of the time was spent talking about what the client was already doing right?

No Time The Whole Session

1 2 3 4 5 6 7 8 9 10

10. How helpful to the client was it to highlight what you were already doing right?

Not Helpful Very Helpful

1 2 3 4 5 6 7 8 9 10

11. How much of the time was spent talking about how the client would like life to be?

No Time The Whole Session

1 2 3 4 5 6 7 8 9 10

12. How helpful to the client was it to talk about how you would like life to be?

No Time The Whole Session

1 2 3 4 5 6 7 8 9 10

Appendix 5

Solution Focused Research Check List

	PLEASE TICK
Before First Session	
Take new client pack and note the client code in your notes.	
Add your therapist code to the front of pack.	
Remove small envelope that is labelled "Before Start"; this should include release form, goal statement sheet, and Coping Resources Inventory. Have client fill in all three:	
Release Form	
Goal Statement Sheet	
1st Coping Resources Inventory	
Fill in Client Information Sheet	
(Collect all information and keep in large envelope)	
At End of Fourth Session or Last Session if Less than Four	
Give client 2nd Coping Resources Inventory	
Give Client Perception Questionnaire	
Fill in Therapist Perception Questionnaire yourself	
(Collect all information and keep in large envelope)	
Three months after termination or 3 months after last appointment	
Send client feedback forms in the small envelope marked "3-month follow-up" or invite client to come back in to fill in the forms. The address to send the information will be on the client release form.	
Keep client release form in client notes	
Fill in therapist goal sheet	
Seal the large envelope with all information (except the "3-month follow-up" envelope sent to client) and send it to City University	

REMINDER DATE CHART

Date of first session: FILL IN FORMS
Date of second session:
Date of third session:
Date of fourth session: FILL IN FORMS
Date of fifth session:
Date of sixth session:
Date of seventh session:
Date of eighth session:
Date of ninth session:
Date of tenth session:
Date of eleventh session:
Date of twelfth session:

Three months after last session, send follow-up envelope or invite in.

Appendix 6

Client Information Sheet

Client Code: _____

Therapist Code: _____

Sex: Male Female

Age:

Race: White Afro Asian Oriental Other

Employed Unemployed

Presenting Problem:

Length of Presenting Problem:

Has the client sought any type of assistance with this problem in the past?

Yes No

If yes, what type of assistance?

Number of Session:

Date of first session:
Date of second session:
Date of third session:
Date of fourth session:
Date of fifth session:
Date of sixth session:
Date of seventh session:
Date of eighth session:
Date of ninth session:
Date of tenth session:
Date of eleventh session:
Date of twelfth session:

Appendix 7

It has been about three months since the end of your therapy at The Brief Therapy Practice. Would you please fill in the Coping Resources Inventory with the pencil provided and send the completed form back to City University in the enclosed envelope. It is not important to fill in the top section of the form.

Thank you for your time and effort.

Case Study of Solution Focused

Brief Therapy

Melissa A. Darmody

Doctorate in Counselling Psychology

City University, London

Abstract

The aim of this paper is to give the reader a detailed description of how Solution Focused Brief Therapy (SFBT) can be used in a clinical context. The paper introduces the theoretic model and then uses a case study of a client bereaved through suicide to show the model's effectiveness in enabling the client to access his or her own resources. There is a critical assessment of the effectiveness of the model's intervention and discussion into other interventions the practitioner may have used.

Introduction

The counselling profession is under increasing pressure in today's economy to provide value for money in helping people overcome the tragedies of life. More and more counselling services are being asked to provide short-term counselling to clients in order to reduce costs and decrease waiting lists. There has been a huge expansion in the number of new ideas in the area of brief therapy. One of the main impetuses behind this expansion has been the needs of the many professionals struggling to provide a cost-effective, quality alternative to traditional forms of therapy.

My own interest in short-term therapy models developed in a work context where I was asked to provide a limited number of sessions in a work related setting. In developing ideas in relation to short-term work, I found it difficult to alter traditional models in order to use these successfully in a short-term context. I began to establish contacts with other practitioners who were interested in working with short-term techniques, and began to develop models that streamline work with clients. I was able to find a preferable model which would be compatible with ideas based on the client's abilities to help themselves and develop their own coping resources that already exist.

This paper will examine a case study in order to show how difficult cases, which would have been traditionally recommended for long-term work, *can* be dealt with effectively using short-term models.

Theoretic Model Used During Sessions

The context in which I was employed at the outset of this research - an in-house counselling service provided by an international entertainment company - required short-term counselling, with a maximum of eight sessions a year with any one employee. The service was provided with the intention of helping employees recover from personal or work-related crises, partly by helping them to access *their own* resources and strengths, thus enabling them to function more productively and reach their goals and potentials. The counselling service employed an eight-session model with the twin aims of keeping the waiting list down *and* empowering the client, by encouraging them to take responsibility for their own recovery and progress, within that time period.

Steve de Shazer and others originally developed solution focused therapy at the Brief Family Therapy Centre (BFTC) in Milwaukee, Wisconsin, USA (de Shazer et al., 1986). Their research looked into the effectiveness of the general systems theory and the application of traditional Ericksonian clinical practice, which pays detailed attention to patterns of exceptions to problems, seeing such exceptions as clues to solving these problems (Berg & Hopwood, 1992). The belief underlying this form of therapy is that it is not necessary to understand *all* aspects of a problem in order to find solutions to it. Steve de Shazer compares the working methods of traditional and brief therapy models to travelling to the same place in a city by bus or underground. One takes a circuitous

route involving visits to many parts of the city, bad roads, and encounters with many other vehicles, while the other travels smoothly in a straight line, avoiding unnecessary and time-consuming stop-offs, and arriving beforehand. Traditional and SFBT therapists, therefore, use different maps to get to the same destination. Although there are no completely 'smooth rides' in therapy, this nice analogy conveys the fact that SFBT is simple in theory, yet often challenging to put into practice. Once its ideas are mastered, they are extremely effective in enabling the client to develop clear goals and identify what he or she would need to do so as to change the problem behaviour.

SFBT is concerned, then, with *empowering* the client to take control of their life and to proactively search for solutions to their problems by identifying, acknowledging, and developing those aspects of their behaviour which have a positive net effect on the problem in question. Periods when the problem is not perceived as existing, or when its negative symptoms are not felt, are known as 'exceptions'. This is an important concept in SFBT. With any problem, there is almost always a time in the client's daily life when it is absent, however briefly or unconsciously. The SFBT practitioner is always trying to identify those areas of client behaviour which eliminate or reduce the effects of a problem, as well as encourage the client to make these helpful behaviours happen more frequently. If the client does not want behaviour to be happening, the therapist would ask what the client would like to replace it with. It is much easier to concentrate on increasing the

replacement behaviour than it is to work on decreasing the unwanted behaviour.

The three golden rules of SFBT practice might be summarised succinctly as: (1) "If it's not broken, don't fix it", (2) "Once you know it works, do more of it", and (3) "If it doesn't work, don't do it again, do something different" (Berg, 1991). These three simple rules outline the basic principles of the theory.

"If it's not broken don't fix it" means that the therapist should not create a problem for the client which they do not perceive themselves as having. If the client does not label a particular issue as a problem it should not, therefore, be referred to by the therapist as a problem. Essentially, the therapist should not pathologise the client's issues. The idea of client resistance is redundant in SFBT. On the contrary, what other schools of therapy refer to by this term is seen in SFBT as clients' own unique way of, in fact, *co-operating* with therapists, by showing them what is not working (de Shazer, 1989).

"Once you know it works, do more of it". One of the main tasks of any therapist is to identify what is already working in the client's life, and aspects of their life they wish to retain, and encourage them to do more of that. SFBT holds this belief with *all* problems; there is always an exception to the rule. In other words, in every case where a person reports a particular problem, there are also always periods when the problem is *not* present. The SFBT therapist should, ideally, go into these periods with the client in some depth, finding out as much as they can

about them, and characterising in some detail what is different about them. In many cases, simply complimenting the client on those occasions when they act in such a way as to neutralise or reduce the effects of a problem is enough for them to feel sufficiently empowered to increase the incidence of these "exceptions" to the problem, thereby minimising it. Whenever possible the therapist should give the client the credit for when they, as it were, "do things right". One technique that can be useful in this area is asking questions about pre-session change. Often the therapist will enquire about which things the client has done since making the appointment, or in the last couple of days, that have made a difference to the problem in question. Often the client has in fact already started to make positive changes in their life. Some 40% of clients report some form of pre-session change, and 15% report significant pre-session change (McKeel, 1996). In many cases, the very act of making the appointment and coming to the session represents a significant change with regard to the problem behaviour. Pre-session changes – however small - can be built upon and classed as 'things the client is doing right'. This approach also gives the therapist an opportunity to give the credit for the improvement to the client, thus empowering them to make further changes.

The third golden rule is "if it doesn't work, don't do it again, do something different". This is a guideline which both client and therapist should adhere to. If the client were continually repeating a certain behaviour pattern, the SFBT therapist would encourage them to think

about what elements of their behaviour they could alter, no matter how small these changes might be. SFBT is different to other forms of therapy on several levels: it believes that (1) change is inevitable, (2) only minimal changes will solve problems, creating a ripple effect, and (3) change in one member of the system changes others (de Shazer & Molnar, 1984). If, therefore, you are able to create or facilitate change, no matter how small, you are creating a difference to the problem. If the difference makes the problem worse, then the client should "do something different". This final 'rule' forces the therapist to be creative in their approach to the client, in that they need to be able to work and think about the problem in different ways. Nothing will work for everyone every time.

The concept of scaling questions is another powerful tool used in SFBT to provide the therapist with a better idea of the client's perception of the problem. The following is an example of a scaling question: "If you were on a scale of one to ten, where one is the worse the problem has ever been, and ten is when the problem is solved, where would you be at the moment?" Scaling questions can help to achieve several useful ideas. Firstly, they "measure" either the client's own perception of the problem or that of other people in the client's life. The client may, for instance, be asked, "Where would your husband place you on the scale?" Scales can be used to motivate and encourage the client and also to evaluate goals. Questions such as "Where will you have to be on the scale to stop coming to therapy?" or, "What would a four look like?"

can all be used to evaluate the client's perception of the problem (Friedman, 1993). Scaling can also help the therapist identify pre-session change, using such questions as "how did you get to a five?" or "how are you managing to cope at a one?" These questions lead the client toward finding recurring exceptions to their problems, as well as resources, which help them to cope with a difficult situation.

Another aspect of SFBT is its focus on what the client wants to be doing differently. The therapist would, for instance, ask the client what they would be doing if they stopped fighting with their husband or how would they know they were coping with the situation. The SFBT practitioner is continually trying to paint a detailed picture of what could go right for the client, as opposed to what could go wrong.

SFBT uses *compliments* to a significant degree. Just as the therapist is always seeking to identify what the client is doing right with regard to their problem, they also always actively attempt to point out the client's strengths and achievements in working towards the goal of a problem-free life. The therapist may comment on how much hard work the client has already done in their attempts to deal with the problem, and point out the strength of character they have already shown by managing to cope with such hardship. It is important to phrase these compliments in an appropriate way, so as to sound encouraging and not patronising. It may be that the client has not previously received any recognition from friends or family for coping with a difficult situation. A general rule of thumb is to find three aspects you can compliment the client on within

each session. The idea that the therapist is looking for the positive within the client puts the whole session in a context far removed from those therapy styles where the client simply elaborates on their problems at length.

SFBT seeks to create a friendly, positive atmosphere within which the therapy takes place, and to use normal, everyday, conversational language in a respectful way. As often as is possible, it is important to use the client's own words in one's responses, in order to demonstrate that the therapist is, indeed 'listening' to the client. 'Common sense' and basic observational skills have an important role in discerning what the client is, as it were, 'doing right' and in the process of feeding back positive compliments. Similarly, the therapist should always maintain a positive, hopeful view of the client (Berg, 1991).

In the form of SFBT which was developed in Milwaukee, no limit is set on the number of sessions available to the client. In company-based services the situation is different. In the service provided by PolyGram UK in the mid 1990's, clients were limited to eight sessions per year. It was recommended that at the beginning of each session the therapist reviewed with each client how many sessions remained. As well as informing the client of the time frame needed to work to, this also prepares the client for the ending from the very outset of the therapy process. This is important, since in brief therapy termination comes quickly. The client chooses at what intervals to come for sessions. Once again, this empowers the client to take responsibility for their problem

and for finding a solution to it. The client is asked when or if they think it would be "helpful to schedule another appointment." In most cases the client chooses to come at shorter intervals at the outset of therapy, and once they feel they are starting to cope better, they begin to request an extension of the intervals between sessions.

Using a case study, some of the techniques described above will now be demonstrated.

Biographical Information

The client is a white American female aged 27. She obtained a University degree before leaving the United States, and had been living in London for the ten months previous to the therapy, because she felt she had more in common within English culture. The client is single and lives on her own in the city of London. She has worked for the past ten months in the music industry. This is the second time the client has sought counselling.

Family history

The client, an only child, was born in South America to European parents, and raised in New York City. She describes growing up as "never really fitting in" because she was so different from the other children. She felt her experience of growing up in various countries with foreign parents made her stand out from other children in her age group.

Her parents divorced when she was 15, an event she describes as "traumatic".

After her parents' divorce she went to a therapist who she found particularly unhelpful. She reports that the therapist just "sat and stared at" her. She later found out that the person in question was unqualified, and this left "a bad taste in my mouth" regarding therapy.

Her mother is single and currently lives in New York. The client's father has remarried and lives with his new wife in Paris. The client is in close contact with both her parents and considers her family supportive and close, although she describes her relationship with her stepmother as strained.

The client moved to London ten months ago after living in various parts of the United States. She felt that she had "little in common with American men".

Client's Reason for Seeking Help

Two months after moving to England the client began to date her most recent boyfriend. She described the first two months of the relationship as "bliss". After this point the balance of the relationship was upset due to her boyfriend's depressive moods and her having an unwanted pregnancy. The client's boyfriend wanted to keep the child, yet the client chose to terminate the pregnancy. After the termination of the pregnancy their relationship began to fail. Three weeks before contacting the counselling service her boyfriend committed suicide, after which the

client found his body in a park they used to frequent as a couple. He had taken a heroin overdose. The method of his suicide was particularly meaningful as her boyfriend never used drugs and was emulating the death of a close friend of his who overdosed two years previously.

After her boyfriend's death the client realised that he had been stealing money from her bank account over the last months of their relationship. The client was confused regarding the stolen money and simultaneously grieving the loss of her boyfriend. She felt that she was having difficulty coping with the present situation and needed help to "survive" this event in her life.

Context in which the Counselling Took Place

The client's employers supply a free, internal counselling service to all their employees for short-term counselling. The employees can self-refer to arrange an appointment with one of the two counsellors in the team. The appointments can be made on or off the work-site and flexible hours are available to meet the client's needs. There is initially an assessment session to evaluate if short-term counselling is appropriate for the client. There are eight sessions available in total. This service had been in operation for three and a half years at the time the client contacted the service. The first appointment was scheduled three days after the initial telephone contact.

Contract

During the assessment session, before beginning counselling, a Statement of Understanding that outlines what the counselling service can provide and its limitations was reviewed with the client (See Appendix 1).

Goals: Our contract was to help the client feel like she was coping and work towards defining her relationship with her boyfriend, so she could say "goodbye". This goal was developed during the first session by asking the client what she wanted out of counselling and what her expectations were.

Time: We contracted for up to six sessions after the assessment session and a termination session. Eight sessions were available in all. Each session lasted an hour in length.

Structure: The therapy took place at the therapist's office in the centre of London. The office was used exclusively for counselling, and the appointments were pre-arranged. A twenty-four-hour cancellation time was required. The therapist would wait the whole hour for the client if the client was late or missed an appointment. If an appointment *were* missed without cancellation the therapist would try to reach the client by the designated telephone contact number and then by letter (See Appendix 1).

Limits: The limits of the eight sessions were discussed in the beginning of therapy, and the expectations for the therapy were explored. The possibility that the client may want a long-term referral was discussed during the assessment session.

Boundaries The telephone number and times that the therapist would be available were discussed. Outside of contact hours the Samaritans, a 24-hour support service, telephone number would be available from an answering machine.

It was agreed that outside the therapy sessions the therapist would not acknowledge that they knew the client personally, unless the client clearly chose to acknowledge the therapist. It was stated that the therapist would not discuss relevant issues outside the therapy sessions. These measures were taken to protect confidentially.

Confidentiality: It was stated that the information shared would be kept within the counselling service, which included the counselling team and the supervisor. If there was any concern regarding harm to self, another, or the company, that the therapist may have to reconsider the limits of confidentiality. The fact that the counselling service fed back statistical information to the company was discussed, and it was made clear that none of the information fed back to the company would involve the disclosure of an individual's identity.

Supervision: This case was presented and monitored in a fortnightly supervision session with the counselling team and supervisor attending.

Overall Content of the Sessions

Session One

At the beginning of the first session I gave the client a summary of the way I work and discussed what the client could expect from me as a therapist. After discussion the client signed a "Statement of Understanding" to show she understood certain agreements (see Appendix 1).

The client began by expressing concern over the limited number of sessions available. We discussed this, and decided to make a decision by the end of the session as to whether the client felt it was appropriate to be referred to a long-term counsellor. The client then discussed a past counselling experience, at the age of 15, when her parents were divorcing and she was having great difficulty adjusting at school. She described the experience as "three months just staring at this man" who she later found out had little qualifications. At this point we discussed how I work and that I was interactive and would be asking her questions. The client seemed pleased with this. I then asked the client what her expectation of counselling was and she began to tell her story.

She said that three weeks ago her boyfriend of eight months had committed suicide. She was currently trying to come to terms with this event, and although she was level headed and realistic in other aspects

of her life, she felt she had chosen 'bad' people to have relationships with. The client then began to talk about her family background, and the reasons why she had chosen to move to London. She moved to London 10 months ago because she felt she would fit in better there and had little in common with American men. She described the first two months of her eight-month relationship as "a high". Although she and her boyfriend had very different backgrounds, she described him as a "good, kind, and a giving person". Their relationship quickly became "serious". He was close to his family and wanted "the package" of a wife and children immediately, whereas the client was unsure.

Six months previously the client had become pregnant and although her boyfriend was "desperate" to have the child, she terminated the pregnancy because she had too many concerns about the future. This devastated him and there was a suicide attempt by him at this time and for the next six months the relationship became difficult. He became very depressed, yet did not share this side of himself with anyone other than her. The client then talked about previous suicide attempts made by her boyfriend two years before she had met him. These were triggered by the death of his best friend from a drug overdose.

The client stated that looking back over the relationship from that point, she realised that her boyfriend started stealing money from her soon after the abortion. He began taking her bankcard without her knowledge and withdrawing money. She had been having great difficulties with the bank and these unauthorised withdrawals had put her

in debt. She could not understand how he could have watched her go through so much trouble with the bank, knowing that he was the cause of it. Just before his death her boyfriend had stolen her whole wallet, and the client felt that he was trying to cause a split with her and therefore he would be "free to die". He had been "sabotaging" the relationship. The client finished by saying that she contacted her boyfriend's family after he had not appeared home for several few days. When she began to look for him with his family, she found him dead in the park which they used to visit. He had taken a heroin overdose, although he was not a drug user. She believes this method of suicide was a tribute to his best friend who had died a few years earlier.

At the close of this first session, we discussed whether the client felt she wanted a long-term counselling referral, as well as what the client wanted to get out of coming to counselling, in terms of a realistic goal. She stated that she wanted to feel as if she was coping with her situation and surviving it. She also wanted to gain some understanding as to why her boyfriend had been stealing money from her. I was thus able to create a picture of what the client wanted and decide if these desires were realistically attainable. I also tried to establish some pre-session change by asking questions about what she had been doing to cope since she called to make the appointment. By the end of the first session the client had been able to tell her story and establish the goals of coping better and defining her relationship with her boyfriend, so she could then say goodbye. I used some scaling questions to gain a feeling of how the

client imagined she was coping. I would use this scale throughout the sessions to monitor the progression of the therapeutic process. At the end of the session the client chose to make an appointment in one week's time.

I felt that the relationship between the client and myself was particularly strong because we were of similar age, sex, and background. We were both Americans who had chosen to live in London. At the end of the first session the client and I had established a relationship strong enough to allow her to tell her story.

Session Two

My objective for this session was to find out from the client how she would be able to meet her defined goals of coping better and defining her relationship with her boyfriend. I was interested in developing what she was already doing that would help her met these goals.

The client stated that since the last session she had been looking through her diary and matching up the times she and her boyfriend had fights to when he had stolen money. These were steps to piecing together and defining her relationship with her boyfriend. The client was very talkative. I asked her several questions about how she would know she was coping successfully, and what she would be doing differently if she *were* coping. I asked her several 'scale' questions, and how she would know she was moving up the scale, all the time attempting to get a

sense of what "coping" meant to her and what she would be doing that would show her she was coping. Again, this line of questioning was aimed at establishing more clearly what her goals were: she wanted to be coping, but what did that mean in behavioural terms? What would be happening in this client's life for her to know she was coping? During the session the client began to cry while talking about one of her last meetings with her boyfriend. The client came across as reluctant to show or display her feelings and I felt that her being able to "break down" in front of me and be accepted was reinforcing our relationship. I gave the client positive feedback regarding her strength and courage. I also pointed out several things which she had said were helping her survive. At the end of the session the client chose to make an appointment for a week's time.

Supervision

After the second session I took the case to supervision. Issues discussed included my experience of the client and our similarity in terms of reluctance to display emotion as well as choice of lifestyle, as well as the client's support system in London. There was agreement that the client was experiencing a feeling of being alone and abandoned in London. This issue became an important aspect of the supervision, and I decided that it was important to explore this in more detail.

Session Three

The third session began with a statement of how many more sessions remained, a practice I frequently use in order that the client is always aware of the fact that the time period we have to work together is limited. I asked the client some questions about her support systems. This theme developed, and in fact the client spent the rest of the remaining time talking about her support systems and how these were helpful in meeting her goal. This highlighted for the client the importance to her of having supportive people around in enabling her to cope better.

This is a good example of how the SFBT model works, by focusing on and developing those elements of the client's behaviour which are helpful to them, in terms of reaching their goal, in this case coping with bereavement. During this session the client spoke of a realisation that asking for the support of family and friends was helping her to both cope with the immediate bereavement and, as it were, 'move on' from it. At the end of the session the client chose to schedule an appointment for two weeks' time.

Session Four

In the fourth session we looked again at our initial contract. When I asked where the client felt she was on the scale, she said she *did* feel less guilty about the death, but was, however, still unsure of her ability to cope with its aftermath. I asked her questions such as "how will you know you are ready to say good bye?" and "how will you know you are

coping?" She again talked about support network, and how this helped her cope with the situation. The client began to talk more about the present and the future, and less about the past. She said she wanted a "light house" to aim for. This showed me that the client was goal-oriented, and wanted solutions to her problems. Again, I fed back the client's strengths from what she revealed about herself. The client made an appointment for two weeks' time.

Session Five

In the fifth session I used the client's previous reference to the image of a 'lighthouse' to find out what she was doing to allow her to cope and move on, since the first session. She talked about telling a friend in America what had happened, and how this had given her some new insight into the situation. I asked her what would need to change for her to feel like she was moving on, and she responded that she *would* know she has moved on when she does not have to "go over everything constantly". I asked her what would help her not to need to review things constantly. She felt it was useful to go over things because each time she did she was closer to "laying it down". Again, by the end of this session, we agreed that what the client would have to do to feel she was coping and moving on would involve, on the one hand, gaining support from friends and family, as well as telling her story until she can "lay it down". I complimented the client on the strengths and resources she had

exhibited. The client was going to America to visit (for support), and would contact me upon returning.

Session Six

Two months later, we had our sixth session. It was immediately apparent from the way the client appeared, that something was different. She was smiling at the beginning of the session, and looked more relaxed in her body posture. Her tone of voice was steady and clear. The session revolved mainly around her trip to America, and focussed on drawing out various aspects of what she was 'doing right' to help her deal with her boyfriend's death and saying goodbye to him. The client was able to name several things that she felt were beneficial, and we agreed that she should do more of them. Two examples which arose were talking to friends and family, as well as keeping a journal. She also spoke about allowing herself to cry and feel sad, and not feeling that she had to be strong all the time. In closing, we discussed the number of sessions left, and the client chose to make an appointment for two months' time, feeling that she knew what she was 'doing right' and wanted to come back for a further session to 'check in'.

Session Seven

In the seventh session, the client talked about her awareness of needing to ask for what she wants in a relationship, and being able to ask for support and assistance when it was appropriate. These were

important tools in the process of her coping. Once more, she reviewed what had been working for her in terms of coping and 'saying goodbye', over the past two months. We again agreed that she should do more of what was working, and, as before, I gave her compliments on her strength and courage. At the close of the session, the fact that the next session would be our last meeting was referred to. The client chose to make an appointment in a month and a half.

Session Eight

In the termination session, we reviewed what we had discussed through the course of the past seven sessions. We had highlighted and expanded upon those things the client was doing which helped her cope and 'say goodbye' to her boyfriend. These were, principally: asking for, and gaining support from family and friends; keeping a journal of her feelings; and allowing herself to express feelings of sadness and loss. The client described the experience of dealing with her boyfriend's death, and its consequences, as like being on a roundabout and "going round and round in a circle". She now felt that she knew she would eventually get off the roundabout when she had chosen a path, and that she now felt she knew how to cope with being on the roundabout. For the present, she felt it was okay for her to be there. I was attracted to the image the client had chosen to represent her current situation. Given the necessarily limited time available to work with clients which the work based practitioner can avail of, the client is assisted back on the road to

recovery, but the therapist may not actually be present when the client reaches their recovery goal. I believed that this client would, as she stated, "choose a path" in her own time, and that indeed what she wanted from therapy was, for that moment, to cope with being on the roundabout. Furthermore, at the completion of our allotted course of eight therapy sessions, she felt, with justification, that she possessed the necessary tools to cope with the issue which had brought her to therapy in the first place, and that she had always had them. I feel that the client was able to identify these tools by being focused on the goals she wanted to achieve by coming to therapy and examining what she was *already* doing to help her reach these goals. Therapy served to highlight for the client the coping resources she already had and gave her the encouragement needed for her to trust her own support systems.

The Client's Definition of the Problem

The client's definition of the problem was an awareness that she was not able to cope with the suicide of her boyfriend of eight months. The client was trying to "survive" through her grief, as well as come to a better understanding of her relationship with her boyfriend.

The Counsellor's Definition of the Problem/Diagnosis

In Solution Focused Brief Therapy the therapist does not focus on underlying problems. Therefore the counsellor would accept that the client's definition of the problem was, indeed, the real problem. Thus, in

SFBT, the client both defines the problem and sets the agenda for work. In the present case study, for instance, the client wanted to cope with her bereavement and understand her relationship. She does mention in the counselling sessions that she "picks the wrong relationships", yet this is not followed up, as it is not part of the main agenda as outlined by the client.

The Approaches, Strategies, and Techniques Adopted with the Client

Solution Focused Brief Therapy was used when working with this client. One of the basic assumptions of this model is that attempting to understand the cause of the problem is not a particularly *useful* step in the process of arriving at a resolution to the problem. Unless the client feels that it is part of their goal to understand the cause of the problem, I do not work with underlying causes.

Another basic SFBT assumption is that, irrespective of the nature and seriousness of the problem in question, there are always periods when the client is already engaging in some behaviour which can form part of a solution to it. The task of the therapist is to help the client both to achieve an ever greater awareness of what it is that they are already doing right, and to do more of it.

In the case study under discussion, I attempted to get an expectation or goal from the client for coming to therapy at a very early stage within therapy, by, for example, asking the client to talk about what

she expected to get from coming to counselling. This can simply be put, "How can I help?" or "What can we do together that would be helpful?" The client was very clear about what she wanted from counselling, and was able to discuss this in detail. Her main concern was coping with and understanding her loss. Following this I asked the client questions about how she was coping, and how she would really *know* she was coping, thereby trying to identify for herself the actual behaviour which would need to be taking place for her to feel that further therapy was useful.

I also tried to establish pre-session change, finding out what the client is already doing that is helping her cope. This has two principal benefits: she was able to pin-point behaviour which is already proving successful for herself in the coping process, in order to build on it at a later stage, and secondly, we can give the credit for behaving in this way to the client and in doing so, empower them, and not the therapist, in the healing process.

I also asked the client to place herself on a scale of coping. This technique, known in SFBT as 'scaling', allows the therapist to obtain a clearer idea of the client's perception of his or her difficulty. Scaling also allows the therapist to ask about the future. Questions such as "what would be happening if you were at a five?" or "at what number will you know that you do not need to come here again?" help the client to envisage a solution in the near future.

Early sessions were chiefly occupied with allowing the client to tell her story. I felt that if I moved this client too quickly into solutions, she

would not feel as if she were really being 'heard', and the relationship would be damaged. Although working with the SFBT model *does* mean that the therapist does not focus excessively on the problem, neither is the model "problem phobic". In fact, in this case study, part of this client's way of coping with her problem turned out to be the very act of telling her story, helping her to, as it were, 'lay it down'. She stated several times during the therapy that she felt it was important for her to talk to people about the bereavement, and that each time she told her story she felt closer to letting it go.

The main area of work with this client was finding exceptions to the problem. Much discussion focussed upon times when she felt she was coping, and what was different about these times. We were then able to develop these exceptions to the problem (coping times) and decide at the end of most sessions what the client should do more of, to help her cope.

Other Theory

When working with the present case, in addition to SFBT techniques, the framework of Worden's (Worden, 1983) four tasks of mourning were kept in mind:

1. To accept the reality of the loss.
2. To experience the pain of grief.
3. To adjust to an environment in which the deceased is missing.

4. To withdraw emotional energy and reinvest it in another relationship.

While helping the client become aware of the solutions that would enable her to cope and say goodbye to the relationship, I was aware of issues that Worden sees as the principles and procedures in working with bereaved clients:

1. Help the survivor actualise the loss.
2. Help the survivor to identify and express feelings of:
   anger, guilt, anxiety, helplessness and sadness.
3. Assist living without the deceased.
4. Facilitate emotional withdrawal from the deceased.
5. Provide time to grieve.
6. Interpret "normal" behaviour.
7. Allow for individual differences.
8. Provide continuing support.
9. Examine defence and coping styles.
10. Identify pathology and refer.

I find it useful to keep these issues as a backdrop to my work with bereaved clients. I am therefore able to work with a Solution Focused Brief Therapy model, while considering these issues in a wider context.

The Application of Psychological Knowledge Theory and Research Studies to Understanding of Work with the Client

Solution Focused Brief Therapy was originally developed by Steve de Shazer and his colleagues at the Brief Family Therapy Centre in Milwaukee, Wisconsin, USA. Publications examining this work began to appear in the mid-1980's, and have been proliferating since then. In outcome studies conducted at the Brief Family Therapy Centre between 1992 and 1993, it was found that upon completion of therapy 26% of the valid cases showed no progress, 49% had moderate progress, and 25% showed significant progress. At a final outcome, 7 to 9 months after their last session, 45% of clients said that their goal for treatment had been met. An additional 32% said that even though their goal had not been met, some progress *had* been made, and only 23% said no progress was made. This same study determined that solution focused therapy is equally effective across a diverse range of clients and client problems (DeJong & Hopwood, 1996).

Progress, Difficulties Encountered and Attempts to Overcome Them

The client's progress reflected the Solution Focused Brief Therapy model. The client chose for herself if she wanted to return to therapy, and at what point it would be most useful to her to do so. Therefore the frequency of the sessions was spread out over an eight-month period. Initial sessions were scheduled more frequently, but as the client became

more confident in her coping ability she felt she wanted to extend the time between sessions.

One consideration was the decision to use a brief therapy model with a client who was recently bereaved by a suicide. During the assessment period of the first session, I debated if SFBT was the most appropriate model for the client. The client had herself brought up the idea of having longer-term therapy. When working with a limited number of sessions, it is important to establish that the client has a clear idea of what their goals are, and that they are, as it were, a 'customer' for therapy in the first place. They must be able to see change as a product of their actions. During the assessment, the client spoke of wanting a form of therapy that would be interactive, and was very clear about her goals and expectations in relation to coming to therapy. It was immediately clear that she wanted to know what *she* could do to help herself cope. I decided to use the Solution Focused Brief Therapy model because of the client's clarity on these areas, and felt that the chosen model was ultimately extremely useful to the client.

The Development of the Therapeutic Relationship and Notable Aspects or Difficulties with this

Both client and therapist were American females in their mid twenties. This similarity in frames of reference strengthened the therapeutic relationship very quickly in the first sessions, and the client felt able to tell her story quite promptly. It was important for the client to

be able to feel comfortable enough to break down in front of the therapist and show great emotion. At several points when the client began to cry, it was noted that this was a very uncomfortable feeling for her. This was discussed with the client, not as a problem, but as a compliment that she was able to show her emotions in the session despite feeling it was very difficult to do so. I felt that these compliments strengthened the relationship by not pathologising the client's aversion to breaking down in the session.

In finding solutions to the problems, the client identified talking to people about the bereavement and being able to show and express emotion freely as the things that were helping her reach her goal. I felt it was important for the client to have the experience of feeling comfortable enough to express emotion in the sessions and realising that this was a helpful behaviour for her.

A Critical Assessment of the Effectiveness of the Counsellor's Interventions

I felt that overall the therapy was useful to the client. The client concurred with this opinion often when asked at the end of a session if the work we were doing was useful. During our termination session I felt that although the client felt like she was coping and would "survive", that she would have liked a longer-term counselling contract. The client stated that she had met the goals she had laid out in the beginning of the sessions, or was at least working towards them. Yet I felt the client

would have liked to continue in therapy after our limited eight sessions. I offered to give the client a longer-term referral if she felt this was appropriate. The client, however, did not want to take another long-term referral's details at that time.

By asking if she wanted a longer-term referral, it is possible that I was attempting to meet my own need to know that the client was safe, whereas in fact I should have trusted the client. She *did* say she had got what she wanted out of therapy and she did *not* ask for a referral phone number. My suggestion for a referral number may have made the client think she was in a worse state than she was, or that I did not notice all the progress she had made.

Self-Evaluation of the Counsellor's Development of Skills and Psychological Understanding

I felt that this case had been dealt with successfully, both in terms of the client's movement and my own development in working with the SFBT model. The client was able to be very specific about her goals for coming to therapy, and through questioning it was clear that the client was already using coping techniques to "survive". I was able to help the client build confidence in her own coping skills by using compliments, and gaining a detailed picture of what she has been doing right in the past. The client was also able to request what she needed from our time together, by defining that she needed to review her relationship with her boyfriend, repeatedly until she felt this was no longer necessary. This is a

common need of bereaved clients. In professional terms, I was able to strengthen my own belief in a Solution Focused Brief Therapy model.

At the beginning of these sessions I considered whether a less structured approach would be more useful. However, after a satisfactory conclusion had been reached using the SFBT model, I was able to reinforce my own belief in this model and my ability to use it successfully with clients.

Professional Dilemmas and Concerns Experienced

My main concern was whether or not Solution Focused Brief Therapy or any form of brief therapy would prove appropriate for this client, since she was experiencing an acute bereavement, coupled with the confusion of the relationship in the weeks leading up to the suicide. The client felt emotionally abandoned in London and did not have a strong support system in the area. Ultimately, it was the client herself who brought up her concern as to the number of sessions available. During the assessment session it seemed clear that the client was interested in an interactive therapeutic relationship, both from her comments regarding her past therapist, and her stated opinion that the description of the way I work seemed helpful. Additionally, the client's inner strength was obvious, and her strong need to survive the bereavement, and to, as it were, 'keep her head above water' even at the worst moments. I felt that this desire to survive and the strength she had already displayed made the possibility of working in a brief therapy

context eminently feasible. Finally, during the assessment session the client was able to list several detailed and realistic pre-session changes, things she was already doing before coming to therapy which enabled her to cope.

So, in spite of initial concerns about beginning a limited number of sessions with the client, based on the above factors, by the end of the assessment session I felt the client would be a suitable for brief work.

The Use of Supervision Related to Work with the Client

The similarities between the client and the therapist in their beliefs and their coping strategies in handling crises were discussed in detail in the supervisory sessions, as was the client's perception of being emotionally abandoned in London. This was not a topic that was discussed in detail with the client, yet during supervision, both supervisor and peer supervisee felt the client was exhibiting a strong feeling of abandonment. After supervision, the issue of her support structure was raised with the client and this had the intended effect of moving the therapeutic process on. Keeping to the SFBT model, I did not focus on the problem of feeling abandoned in London, but instead highlighted to the client that she coped best when she felt supported. The session then developed with a discussion about the merits of being supported as a fundamental part of the coping process. On the basis of this session, the client began to ask for more support from her friends and family in America.

Summary

I felt that I learned a great deal from this client's case, especially in terms of learning to trust the client to a greater degree, and listening closely to what it was they are asking for from their therapy sessions. In essence, if a client states that they received what they wanted from therapy, the therapist should take their words at face value.

Furthermore, I was able to develop a greater trust that SFBT can be used successfully with a wide range of clients and presenting problems. The successful resolution of this case bolstered my conviction that this model can be used to help clients realize their own powers of coping, and to reinforce their strength.

This case examination has encouraged me to further my professional development in brief therapy models. Initially, I was interested in short-term models of therapy due to the time limits placed on my practice within my working context. In reviewing this case and others I am beginning to establish belief in the solution focused model of therapy in a wide context of therapy. The ethos being that practising in a client led and goal directed way can be applied to all cases. My curiosity within a therapeutic session now lies in where the client would like their lives to go, instead of where they have been and highlighting the client's strengths, skills, and resources.

Appendix 1

STATEMENT OF UNDERSTANDING

I want to take this time to explain to you PolyGram's counselling service so you are clear regarding what it can offer.

The service can offer a confidential counselling service. Anything you may share with me will remain within the counselling service; we take this very seriously so you can share what you need to. The only information that is given to your company is the number of people seen and general trends, nothing that can reveal your identity. The only time I would need to question this confidentiality is if I feel you may cause serious harm to yourself, another, or the company. When notes are made they are securely stored and separated from your name.

The counselling service offers up to seven counselling sessions, not including the original assessment visit. The seventh meeting is used as a review of the work done together, and may take place three months after the end of the other sessions or at another time of your choice. These sessions are one hour in length and are arranged by appointment. It is important to know at least 24 hours in advance if you will not be able to make your appointment, so I can use this time to assist someone else. If I receive no notification that you will not be attending your session, I guarantee to be present for the whole of the appointment, whether or not you are present. If you fail to attend or fail to cancel a scheduled appointment it will count as one of your seven meetings. If you leave it with the counsellor that you will call back for an appointment, the counsellor will trust that you will call when you are ready and will not contact you.

If you do not show up for a counselling appointment I will first try to contact you by the agreed phone number. If I cannot reach you, I will then write you a letter. If you do not contact me after two weeks of receiving the letter I will assume that you do not wish to continue.

I understand the above letter:

_____ _____

DATE SIGNATURE

Contact Telephone:_____

Address or Internal Post:

_____

_____

_____

A Critical Analysis of

Counselling In the Workplace

Within the UK

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Abstract

The aim of this paper is to provide a critical analysis of the literature on Workplace Counselling and a review of the development of counselling in the workplace within the United Kingdom. The paper focuses on the difference between internal counselling services and external Employee Assistance Providers (EAPs) and what common factors facilitate a quality service. It examines the importance of having the different elements of workplace counselling functioning together in order to develop professional standards and ethics and to increase the awareness and quality of services being offered within the UK.

My understanding of counselling in the workplace began to develop with my appointment as service manager for an internal, company-owned counselling service, and the realisation that counselling within the work context is subject to different considerations from counselling in other settings. I began to look into the general development of workplace counselling in the UK, and how this has differed in its development from that in the United States, where most of the ideas which are accepted currently in the UK about counselling in the workplace, originated. In order to gain an understanding of how the profession may evolve in the future, the paper will examine how professional practices have developed up to this point.

A Critical Analysis of Counselling in the Workplace

Counselling in the workplace is a relatively new idea in the United Kingdom. The idea of offering support and counselling to employees developed first in the United States. It has been claimed that some US organisations offered support to their staff as far back as 1917 (Lilley, 1994).

Most studies document the development of counselling in the workplace in the mid-1920's during the now-classic Hawthorne studies conducted at the Western Electric Company's sites in the United States. The original group of "counsellors" were in fact supervisors and other plant employees who had no previous clinical training. They favoured a non-directive, confidential listener's role with "normal" employees (Murphy, 1995). At a certain subsequent point there was a shift from counselling "normal" employees towards treatment of those employees considered to be "troubled".

In post-prohibition America of the 1930's the first work-based counselling services were developed along principles similar to those of Alcoholics Anonymous (AA). Many of these programmes were initiated by employees who were themselves recovering alcoholics (Gilbert, 1994). These services would establish peer help support groups to assist employees' recovery from substance abuse. During the 1950's American legislators gave employers power to take vigorous steps against drug abuse in the workplace, and partially as a result of this, counselling at work began to gain a stronger footing. Counselling

services were supported initially by trade unions. However, control of them subsequently passed into the hands of management, who saw such programmes as a way of assisting employees to return to work (Reddy, 1993b). Between 1971 and 1980 the number of workplace assistance programmes had grown from 350 to 5,000 in the US, a considerable expansion rate for less than a decade (Gilbert, 1994).

In 1974 the National Institute on Alcoholism and Alcohol Abuse adopted the term Employee Assistance Programme (EAP) to describe performance-based intervention programmes in the workplace and thus the modern day EAP was born (Hartwell et al., 1996). Development continued rapidly throughout the 1980's, with health promotion programmes and, in the 1990's, stress specific programmes (Murphy, 1995). The objectives of the EAPs of the late 1990's appear to have shifted towards providing support for employees with a far wider range of personal problems. This shift reflects the EAP field's move from providing a reactive to a proactive service. In the US, EAPs cover a broad range of issues, and offer advice and information services, in addition to counselling. It is not uncommon for EAP providers to employ specialists in legal matters, elderly care, and parenting issues. Therefore employees in the US can contact their company's EAP for advice and help relating to almost *any* issue. This US trend seems to be taking root in the UK, with EAP services expanding to provide information and advice services.

Before discussing the development of counselling in the workplace within the UK, it is important to be aware of the various types of counselling services currently being offered. Counselling in the workplace can range from ad hoc outsourcing policies adopted by personnel departments, which might use a counsellor as a means of, as it were, 'fire fighting' a troubled situation, to a fully integrated counselling and assistance programme available to all staff on a voluntary and confidential basis. It is important that direct access to the service be made available to staff, so they are able to reach the services without the knowledge of individuals within the company (Darmody, 2000). These services may be offered internally (company owned) or externally (contracted out). The remainder of this paper will refer to internal, company owned operations as "counselling services" and external, contracted operations as EAPs.

Internal counselling services within the UK have developed out of Personnel or Occupational Health and Welfare Departments. The background to their emergence can be found in the needs of staff arising within the company and they were usually developed from already existing departments. In-house counselling programmes began to serve the largest client population, with a total of 50 in-house schemes existing in 1995, mainly in the public sector, involving 700,000 employees (Finn, 1995).

On the other hand, Employee Assistance Programmes (EAP) are defined by the UK Standards of Practice and Professional Guidelines as

workplace counselling and other support services implemented in a systematic and readily-available manner to agreed professional standards. They are seen as having twin focuses: (1) to provide counselling and other support services for employees of organisations and (2) to assist the organisation in the identification of productivity issues. The importance placed on the latter is growing within the workplace counselling profession, so that the objective of counselling services and EAPs is not only to help the individual who comes to them for assistance, but to feed back appropriate information to company management, in order to help the organisation anticipate and restructure damaging trends (Dunne, 2000).

Reddy speaks about a perception within the UK that external EAPs seemed to have, as it were, appeared out of nowhere, and were seen by some as simply another idea imported - and often times imposed - from America (Reddy, 1993a). This relates to another contributing factor of the growth of the EAP field within the UK, the desire of US parent companies with operations in the UK to have their UK employees enjoy access to the same employee benefits as their domestic staff. There has been little history of union involvement in external EAPs, and this may account for the perception that some services were 'parachuted' in 'from above', while internal services seemed to have grown organically out of need.

The significant increase in the levels of workplace counselling in the UK may be partially attributed to companies wanting to both keep up

with the latest trends from America and at the same time move away from the 'uncaring' Thatcherite values of the 1980's. Other factors which may account for this development would include higher levels of performance pressure upon the individual; changes in management styles which have a net effect of emphasising "listening" as opposed to "telling"; and increased support for management to adopt a counselling role. The changes in the welfare system have placed more pressure on companies to care for their employees, in the context of a weaker National Health Service (NHS). More companies are now offering benefits such as private health insurance, pension schemes, and counselling services, both to care effectively for their employees' welfare, and to increase loyalty to the company.

In 1993 about 80% of UK companies were offering some form of counselling as a means of employee support. The greatest proportion of these (65%) were using counsellors on an ad hoc basis (Reddy, 1993b), calling upon external counsellors who have no previous knowledge of the company to see employees who find themselves in emergency situations. This form of employee assistance faces the danger of being accused of, in effect, "dumping" troubled employees at the feet of counsellors to "sort things out".

Although 80% of companies were using counselling, very few of these were using the counselling in a systematic way, so as to help *both* the employee and the organisation, thereby incorporating the twin-edged focus of counselling at work referred to in the UK EAP guidelines. In most

cases the counselling only occurred *after* the crisis, when managers and the personnel department had already become involved. Few companies offered the type of service which employees could avail of confidentially in order to seek help *before* a crisis point was reached. Approximately 4% of these companies were using an externally contracted EAP (Reddy, 1993b). Over the course of the late 1990's, external EAP providers operating within the UK gained increased respect from companies, and themselves grew in their ability to service the workplace. Reddy states that it has taken time to gain the trust of the market, but it does now seem that progress in this respect has been made, and the growth-rate of external providers is increasing at a rapid pace (Reddy, 1993b). As of 1995, there were 122 companies providing EAPs in the UK and since then the number has increased (Highley & Cooper, 1995).

According to Highley & Cooper (1995) a generalised lack of understanding exists amongst companies as to what are the exact differences between ad hoc counselling services and internal or external Employee Assistance Programmes. Frequently, the decision regarding what type of counselling service a company will offer in the future is largely determined by the history of counselling within the company up to that point. Did the service grow out of an already existing department, or did the company want to offer a completely new service to the employees? Perhaps the company want to replicate the counselling services offered by their American parent company. A

number of different issues are seen to influence a company's decision to choose between internal counselling services and an external EAP.

Within the UK, internal EAP services have been running for longer and service more employees than external EAPs. The most significant benefit of an internal counselling service is that counsellors function *within* the organisation, and therefore do not have to gain an understanding of the client's work environment from a position of complete ignorance, as an external EAP consultant might have to. Internal EAP counsellors are already familiar with the context within which the employee works. Since internal counsellors are already aware of the working culture of the company in question, and the particular pressures and problems which employees are subject to in that environment at the time they come to the therapist, they are enabled to build a working relationship with the employee quickly, a crucial element in brief therapy, as with all time-limited work (Finn, 1995). The counsellor, then, is able to work within the system and to have an impact on the context within which the employees are functioning, by feeding back appropriate information to company management in order to promote healthy changes within the workplace, and thereby fulfil the twin-focused approach of counselling in the workplace.

Employees will have an existing familiarity with internal counsellors, to whatever degree, and are therefore more likely to feel able to approach them with confidence. Sometimes colleagues will suggest to another employee to visit the internal counsellor because they

themselves found their services helpful. One client who availed of the present writer's service reported: "I never thought I would have come, but when I started having problems my colleague at work noticed and suggested that I come see you, they have come in the past and found it helpful. I never would have thought Tom would come to counselling, but the fact that he came and found it helpful and the fact that no one in the company even knew, including myself, I thought I would give it a try."

Comments like this are typical, and often the prompting and recommendation of a satisfied colleague provides the necessary impetus for an employee to actually come through the door of the service. According to Bradley and Sutherland's 1994 survey, more employees said they would be prepared to use an internal counselling service than an external one. Another benefit of an internal service is that there is a consistent quality of service throughout the company. All employees are seen by the same counsellors, who have a good idea of the context within which they work, since the internal counsellor is an employee of the same organisation himself or herself.

Carroll's 1997 publication looked at the qualities and experiences of internal work based counsellors in the private sector. Her research highlights the wide variety of roles that the counsellor would have: counselling, advising managers, education, and promotion of services to name a few. This research also highlights the need for internal work based counsellors to cope with competing roles and demands and isolation within their role (Carroll, 1997). This research is helpful in

identifying the many responsibilities an internal counsellor has and highlights the type of support internal counsellors might need in order to cope with the isolation. It would be interesting to establish group support services for individuals who participate in internal counselling role and research if these types of support groups act as a helpful reinforcement for the often-isolating job of internal counsellor.

Although many aspects of an internal counselling service could be viewed as positive, these same aspects may, from another perspective, be seen as negative forces. For example, if the counsellor is seen by other employees as too much a part of the organisation, these employees may not feel that the service is a confidential one. An external service might offer sufficient distance for the employee to feel that the service is genuinely confidential (Sugarman, 1992). Two types of services exist: those that provide a one appointment assessment and referral to other community agencies, and those that offer short-term problem resolution and counselling. An external counselling service is more likely to offer a 24-hour, seven-day-a-week contact line that will also be available to members of the employee's family. Few internal counselling services would have the resources to be able to provide 24-hour cover. These round-the-clock telephone lines are usually answered by counsellors who provide immediate support and can then refer the employee on for more appropriate interventions, if necessary. One draw back to this might arguably be that an external service saves money, by dealing with employees over the phone instead of offering a face-to-face

appointment, which would be more costly when provided by an external provider. With regard to costing, Reddy (1993) suggests that it is a cost benefit to use an internal service with an employee number of 20,000 or more, but when that number falls below 10,000 it proves difficult to keep the costs of an internal service down to a figure competitive with the cost of using an external provider.

Arguably, the debate over whether to use an internal or external service, and the relative cost-effectiveness of both, has occupied an inordinate and unnecessary amount of time and resources. What *has*, however, been proven is that *both* can provide a quality service which benefits both employee and organisation (McLeod, 2001). Beyond these debates, it is certainly an important and desirable objective that awareness of the availability and usefulness of counselling in the workplace is increased, and that both internal and external services work together to increase standards, as well as maintain programmes that offer a quality service.

Several factors operate which have a bearing on the success of any counselling program, be it internal or external. One of the most significant is that real support for the new programme is provided by senior management, and that there is involvement in the development of the programme from *all* levels of employee within the company. Additionally, clear pre-set goals and policies must be formalised before the counselling service or EAP begins to operate. If clearly set goals are established, it will prove easier, at a later stage, to measure the

effectiveness of the programme in achieving these previously set goals. If, for instance, the company's purpose is to reduce absenteeism, baseline statistics on current absenteeism need to be prepared, so that these can be compared to rates after the introduction of the counselling service or EAP. It may be that the company is developing the counselling service or EAP in order to be perceived as more "caring" by their staff. In this case, the company would need to decide exactly how to measure the perception of the company by its employees, so as to be reasonably certain, at a later point, that the pre-stated goal of the counselling programme has been achieved.

The counselling service or EAP should ideally be open to all levels of employee, if resentment between staff levels is to be avoided. Additionally, the service needs to offer a "broad brush" approach to problems. It remains to be seen how widely available these services will become in the UK. They may develop into the multi-function services offered by American agencies, where assistance with areas as diverse as legal advice and travel information is encompassed. If the past developments are any indication of future trends, it seems likely that the American model of EAP provision will define the future for the UK-based professionals, and UK counselling agencies will begin to broaden the scope of the service they offer. They are already developing the idea of feeding back information to senior management so as to become proactive in changing the structure of the organisations they work with.

Another aspect of a successful employee assistance service is active involvement of all levels of employees in the ongoing development of the service, perhaps in the form of an advisory committee (Highley, 1996; Monfils, 1995; Murphy, 1995; Reddy, 1993b; Sauter, Murphy, & Hurrell, 1990; Thompson, 1989). It is especially important to have the support of both company management and supervisors so they are able to refer to and recommend the service to employees in an appropriate manner. The most important part of any manager's job is the development of their staff (Harrison, 1994), and this fact may partially account for the negative view of counselling services or EAPs displayed by some managers, who feel such programmes allow managers to abdicate their responsibility of care and development by referring any employees with difficulties to the service. Managers may thus see their role as being partially usurped, and their job de-skilled by the very presence of an internal or external programme (Sugarman, 1992). It is however arguable that with adequate training, neither of these perceptions need exist with any justification.

A trend has developed within business whereby managers are given some rudimentary training in "counselling skills", but this practice involves certain significant risks, especially if these skills are taught without teaching clear limits. If, for instance, an employee follows the advice of a manager in such a scenario, and the employee then suffers harm or loss as a consequence, the manager and organisation in question may face legal action; whereas professional counsellors are

protected by malpractice insurance and are, obviously, trained to deal with personal problems at a far higher level (Buon, 1992). Another possible disadvantage of managers carrying out some personal counselling is that the time spent fulfilling such a role may impact negatively on the completion of their other managerial duties. Additionally, the boundaries of the manager/employee relationship may become dangerously blurred if a manager also takes on a counsellor's role. For example, if an employee tells a manager about sexual abuse suffered in their past, the manager might subsequently treat the employee differently to others within the company, on the basis of this information. For these reasons, it is generally much more preferable that managers refer personal issues to a professional counsellor.

Gaining the support of managers for the adoption of EAPs is hence, crucial, and the optimum way to achieve this goal is to train managers to be able to recognise appropriate situations in which to refer employees to the counselling service or EAP. The manager therefore becomes responsible for monitoring and addressing employees' work performance, but also has a 'safety net' to fall back on, in more serious situations or when the problem relates to personal issues. It would be appropriate to train managers to use interviewing techniques to establish whether the problem is work-related, when they notice falling work performance. In the case of a problem being work-related, the manager should deal with the issues concerned. Therefore it is important for managers to be able to monitor and respond appropriately to shifts in

work patterns and changes in staff behaviours so they are able to assess if the issues causing these changes are organisational or personal. If, however, the work-performance decline is due to personal problems, the manager should remain focused on the work-performance issues, and offer the counselling service as a place of free, independent, professional, confidential, and voluntary assistance (Buon, 1992). It has been shown that immediately after appropriate training, referral rates from managers increase from 28% to 63%, and remain high (Stolz, 1991).

Two other significant factors to be considered when trying to establish a successful counselling service or EAP are: (1) the need for confidentiality and (2) the necessity of the service's location being 'neutral'. With regard to the former, it is clear that immediate access to the counselling service in the company building needs to be positioned so that other employees will not see which of their fellow employees is availing of the service. If the counselling service or EAP is not confidential, people are liable to be stereotyped as a result of using such a service. Their work lives could become worse rather than better as a result of the behaviour of fellow workers towards them (West & Reynolds, 1995). This is why the issue of confidentiality is so central. Similarly, it will not be helpful to have the counselling service rooms placed adjacent to or within the personnel department. In such a situation, the perception amongst employees of the service's impartiality would be seriously

compromised, and it may be seen as a "tool" or extension of personnel and management.

In addition, the counselling service needs to receive an ongoing advertising commitment from the company. This advertising should be sympathetic and creative, in terms of the way it accords with the culture and employee-profile of a particular company. What is appropriate to one site might not necessarily fit another. For example, though on some sites it may be appropriate to put cartoons into the company newspaper depicting appropriate reasons to use the counselling service or EAP, for other sites this might not seem appropriate. The counselling service must always be keenly aware of the type of employee who works within the industry being serviced, remaining sensitive to the concerns and language which would be specifically relevant to *them*. The advertising for the service needs to be presented in such a way as to minimise stigmatisation and maximise take-up (West & Reynolds, 1995). These issues must be constantly evaluated, so as to keep up with developments within the company's staffing structure.

Another benefit of constant monitoring of the take-up rates is that it provides the company with an informed idea of the efficacy (both in terms of level and style) of the counselling service or EAP's internal advertising. A take-up rate of 5-20% telephone contact and 4-10% face-to-face counselling would be considered standard. If the take-up rate drops below these figures, the area of advertising might need to be

addressed, as might the political agenda within the company (Reddy, 1993a; Turner, 1991).

Counsellors working for a counselling service or EAP need to be both aware of the culture of the company *and* able to work in a short-term way with clients. It is estimated that 90% of workplace counselling services and EAPs provide a limited number of sessions whose average is 6 (Highley & Cooper, 1995). Most clients get what they want from the counselling service's contact within an average of 4 sessions (Reddy, 1993b). For this reason, workplace counsellors need to be able to assess quickly if brief counselling will be appropriate for a client. Workplace counsellors should have training in the understanding of alcohol and drug problems, as well as experience in work-related issues. It is important for the counsellor to be able to work in a way that will help the employee deal with the specific problem they have brought to the counselling service or EAP and help that employee to access their own resources as soon as possible. Workplace counselling services and EAPs are primarily concerned with getting employees, as it were, 'back on their own two feet', and carrying out their work duties successfully, having realised their own strengths, rather than more long-term, deep-seated issues.

It is also important to have a formalised audit or evaluation in place to review the goals of the service, one critical aspect of which is to evaluate the company's culture before installing a service or EAP. In this way, the organisation would be able to assess exactly they want the

proposed counselling service or EAP to achieve, and then be able to monitor the successful accomplishment of those goals (Sugarman, 1992). Most organisations take it for granted that the programmes are effective, but evaluations should occur at least annually to see that goals are genuinely being reached. On the other hand, there is the perceived idea that having an audit might jeopardize client-therapist confidentiality. This will not be a factor if the audit is carried out externally (Highley, 1996). An audit can measure the extent to which the following desirable aims are being achieved: (1) that the counselling service or EAP has achieved what it set out to achieve; (2) that the company is getting value for money; and (3) that the company can measure the impact of the service in terms of quantifiable changes in employee satisfaction (Reddy, 1993a).

Although the above points clearly have implications for maximising the value proportional to cost of a given programme, only 30% of companies that have used counselling services or EAPs carried out *any* form of needs analysis or stress audit before deciding to introduce a counselling facility. Another 47% of companies with counselling services or EAPs did not set real performance objectives and of the 53% that did, 45% did not do so in a systematic and independent way (Highley & Cooper, 1995).

One factor which may help to explain why there is this lack of evaluation and audit is that companies often put counselling services or EAPs into place purely or principally to help improve corporate image

and as a result of this, do not see evaluation as worth the cost. According to this view, the very existence of such a programme is an end in itself, even if no employees actually avail of them. Many companies do not understand the whole philosophy behind a counselling facility and simply trust the counselling service provider to ensure quality (Highley, 1996).

Another benefit of evaluation and audit is gaining a good picture of employee perception of the service, both those employees who have used the service and those who have not. In Gilbert's 1994 study, 79% of employees who used their counselling service or EAP reported that the quality of their life showed tangible improvements as a result of their visits, while 89% saw their ability to deal with the problem which concerned them as improved. Furthermore, Highley and Cooper (1995) report that 74% of employees who used counselling services or EAPs believed that they were able to deal with the problem much more successfully, while 85% would use the service again, and 88% believed the service was valued by staff. In another report by an external EAP service reports that 100% of the users found the EAP counselling helpful, 82% reported to have felt better able to cope with their problems, 61% reported significant improvements in concentration at work after EAP counselling, 52% reported being able to work more productively after the EAP intervention, and 34% believed that EAP counselling helped them reduce time taken off from work (ICAS, 1999). Statistics like these can help management to gain a better understanding of both how a

counselling service or EAP works, and how it can help improve the productivity of the work force. It is estimated that between 14 and 20% of the work force is dealing with a personal problem that could affect work performance at any given time (Gilbert, 1994) and that 17 to 23% of adults have one or more major psychological disorders (Sauter et al., 1990). With these types of statistics it is becoming increasingly important for companies to look at how they effectively support staff that have personal or work-related issues which need resolution.

In recent years, developments within the legal environment have also increased employers' awareness of the value of counselling in the workplace. Several high-profile cases have had a particular impact. As a result of the November 1994 High Court ruling on Walker vs. Northumberland County Council, a social worker successfully sued their employers, the Northumberland County Council, for the consequences of a stress-related illness aggravated by working conditions (Scoggins, 1995). In Johnstone vs. Bloomsbury Health Authority, a doctor received a substantial out-of-court settlement for stress-related illness. It is unlikely that there will be a wave of stress-related compensation cases, but such cases have raised employers' awareness of their responsibility for the physical and mental health of their employees. The recent Health and Safety Executive (HSE) guidelines for employers entitled Stress at Work, state that stress at work has to be treated "the same as ill health due to other physical causes present in the workplace". The guidelines contain many valuable ideas about risk assessment, including

counselling, but none of the recommendations are legally enforceable. The Disability Discrimination Act 1995 (DDA) defines a disability as "a physical or *mental* impairment which has substantial and long-term adverse effects on a person's ability to carry out normal day-to-day activities" (HMSO,1995). This would include chronic mental disabilities such as depression. So, in this legal environment, employers are being increasingly forced to look at how they can provide support for their staff and this will, de facto, help to contribute to a greater awareness and utilisation of counselling provisions within the workplace in the UK.

The increased professionalism and media profile of both counselling in general and in the workplace has also increased organisational awareness. There are an increasing number of professional bodies that have involvement in counselling in the workplace: The Institute of Personnel Management (IPD); The Association for Counselling at Work (ACW), a division of the British Association of Counselling; The British Psychological Society (BPS); and The Employee Assistance Professional Association (EAPA). In 1995, the EAPA UK Chapter published the UK Standards of Practice and Professional Guidelines for Employee Assistance Programmes. These standards are periodically revised so as to keep up to date with current trends within the profession. The most recent update to the standards is published in 2000 (Association, 1995) (Association, 2000).

In the US, two professional organisations exist which cater for the needs of therapists and counsellors who work in EAPs: the Employee

Assistance Professional Association (EAPA), of which there is a British Chapter, and the Employee Assistance Society of North America (ESNA). EAPA offers a professional certification involving a combination of experience and a competency test for eligible candidates. The exam covers various areas: work organisation, human resource management, EAP policy and administration, EAP direct services, chemical dependency and addiction, personnel, and psychological problems. Those who are successful in this exam are able to use the title, Certified Employee Assistance Professional (CEAP). In 1996 there were only five CEAPs in the UK. It is felt that the CEAP certification as it stands is not relevant to EAP practitioners in the UK because the exam refers to American practice and law and is not, in any case, widely recognised in the UK. A need, therefore, exists for a UK qualification or accreditation which would evaluate to a precise standard a professional's competence in the counselling at work or EAP area of expertise.

It is important that in the next few years professional bodies work together in the development of standards that reflect workplace counselling both internally and externally and that professional recognition is established to ensure quality services throughout the UK. It is only in recent years that the EAPA has developed standards that services can aim to meet in order to become registered counselling services and EAP providers.

In addition to the development of professional organisations for work based counselling, it is only in the past decade

that the research into the outcomes of work based counselling services have began to appear in the literature (McLeod, 2001). One of the reasons for the lack of research historically is that the process of gathering research is time consuming and expensive, and most counsellors are orientated toward practical treatment as opposed to research. Concerns over confidentiality issues have, to some degree, also hindered research development. Another difficulty encountered centres on the evaluation of comparative effectiveness across services, since no two programmes are the same (Orlans, 1991). The results of a piece of research which looks into the outcome of one particular service cannot be generalised to all workplace-counselling services.

Much of the research that has been done in the UK has looked at the quality or scope of service being provided. In one instance, EAR, an external EAP provider, examined client satisfaction with their service and found that 83% of employees who used it were satisfied with the overall service, and that 96% would return to the service, with 94% saying they would recommend it (Megranahan, 1993). These findings support the idea that employees *do* appreciate quality counselling services or EAPs being offered by their company. But what of those companies that wish to ascertain how the cost of running a counselling service or EAP will impact in practical terms on its business operations?

One of the first studies measuring outcome is a 1980 study of a service which had been running for five years at International Harvester Co., in which the company examined the performance of the 342

employees who used the service. The participants showed marked improvements across a range of areas, with absenteeism dropping by 47%, disability days by 53%, disability payouts by 34%, and average days of confinement by 50% (Orlans,1991). These figures were, of course, pleasing to management

Another private sector company that has attempted to measure their EAP outcome is Whitbread PLC. They installed an external EAP and measured the results of the programme after fifteen months. Staff turnover had reduced by 7%, and the company's half-yearly attitude survey showed an increase in morale. For Whitbread this was a successful project (Finn, 1995). The UK Postal Service was one of the first organisations to provide a large-scale research project into the outcomes of work based counselling. In this research 155 Post Office employees who used the service were given pre- and post-counselling questionnaires. Of the 78 who returned the questionnaire, pre-counselling scores on anxiety, depression and somatic symptoms were significantly higher than the normal sample. The post-counselling scores showed significant improvement in anxiety, depression, somatic symptoms and self-esteem. There was no change in the job satisfaction ratings and there was a significant decrease in organisational commitment. Also sickness absence and days off both reduced significantly (Cooper, Sadri, Allison, & Reynolds, 1990). This increase in employee productively seems to be continuously reflected in the research collected throughout the decade. It is also interesting

to highlight that the effects on job satisfaction and organisational commitment do not seem to be consistently increased with the implementation of an EAP.

This publication was followed by additional research carried out with employees of the Post Office. This follow-up research used the same pre- and post-counselling questionnaire format and matched the treatment group with 100 non-counselled employees matched for age and gender. For the counselling group there were significant positive changes reported in anxiety, somatic symptoms, depression, and positive health behaviours. Like the previous study there was no difference reported in commitment of the employee to the organisation and job satisfaction stayed the same. Sickness absence for the treatment group reduced from 27 days to 11, where the control group stayed the same with an average of 8 days per a 6-month period (Cooper & Sadri, 1991).

The Post Office's counselling service is one of the largest in the UK, with 200,000 employees and 180,000 pensioners and dependants who develop over 31,000 cases a year. In more recent publications the Post Office service reports that their absenteeism rate was reduced by over half, while the number of employees complaining of anxiety and depression fell by 61%. Substantial economies were calculated, with the Post Office estimating savings of £100,000 for every 170 staff who use the service (Finn, 1995). This can be compared to the recent large-scale research project conducted on the

United States Post Office (USPO), with nearly 900,000 employees. The EAP provided to the USPO was investigated with results suggesting a benefit-to-cost ratio of 1.27 to 1.0 for the first year rising to 7.21 to 1.0 for the fifth year. In simple terms this means that for every US dollar spent on the employee assistance programme $1.27 was saved in the first year rising to $7.21 in the fifth year (Stephen & Bingaman, 1999).

This can be compared with the Confederation of British Industry's (CBI) research suggesting that as a minimum an organisation can achieve a £3-£4 return for every £1 invested in an EAP service. One survey by the CBI identified that the workplace policy that was found to have the biggest positive impact on absence was workplace counselling and on average companies with such a service had 2.6 days less absence per employee than companies without such a policy. The CBI equates this to a savings of approximately £60,000 for a workforce of 500 (Industry, 1992). These types of cost benefit analysis have helped in the development of work based counselling by consistently proving that counselling programmes do have an impact on an organisation's bottom line.

The research within the UK that led the Confederation of British Industry to establishing this cost benefit started to appear in the late eighties, but the volume of publications began to flourish through the mid to late 90's. The first published study exploring the outcomes of work based counselling in the UK is Firth and Shapiro's (1986)

research into the effectiveness of counselling interventions with clients drawn from a variety of work settings: health, education, engineering, and civil service. This Sheffield based research provided clients presenting with work-related problems with either 8 sessions of cognitive-behavioural therapy followed by 8 sessions of psychodynamic therapy or psychodynamic followed by cognitive-behavioural. Data was collected at intake, between therapies, at the end of therapy, and at a three-month follow-up using the Present State Examination, Social Adjustment Scale, and Personal Questionnaire. With a sample size of 40 the researchers report that psychodynamic and cognitive-behavioural therapies were equally as effective and that 75% of subjects moved from psychiatric into norm ranges of 'caseness'. The researchers report that 60% of clients improved significantly on work-related factors such as time off and performance (Firth & Shapiro, 1986).

A second research project from Sheffield used a range of psychometric measurements to evaluate the effectiveness of 8 and 16-session cognitive-behavioural and psychodynamic-interpersonal therapy for clients with job-related stress. Assessments were made at intake, after 8 sessions, after 16 sessions (or 3-month follow-up for 8-session cases), 3-month follow-up (16-session cases only) and one-year follow-up. The researchers report that both 8 and 16-session versions of both cognitive-behavioural and psychodynamic therapies

prove to be effective in terms of all measures used (Shapiro, Barkham, Hardy, & Morrison, 1990).

These two research projects developed in Sheffield display a high degree of methodological rigour and developed some interesting results from the data. Both projects show the effectiveness of different types of therapeutic model: cognitive-behavioural and psychodynamic. The publications also highlight the impact of the therapy not only on the individual with increased mental functioning, but the effect that has on the workplace functioning through absence reduction and productivity. These results reinforce the idea that workplace interventions are helpful using various forms of therapeutic model.

The majority of research on the outcomes of work based counselling published in the UK was conducted in the public sector. The first of these publications was Keele University's analysis into the effectiveness of Supportline, an internal counselling service for Kent Social Services, noting reduction on sickness, absence, and turnover figures (Turner, 1991). This same service was later evaluated for effectiveness measuring demographics of clients, number of sessions, presenting problems, and satisfaction. This publication reports that 92% of clients rated the service as good or very good and that clients were consistently more positive regarding outcomes than therapists (Sloboda, Hoplins, Turner, Rogers, & McLeod, 1993).

Other more recent publications outlining research into work based counselling in the public sector is Rogers, McLeod, and

Sloboda's (1995) research into the perceptions of clients and therapists of the usefulness of time limited therapy. They report that 17% of clients were dissatisfied with the limited number of sessions offered, where therapists were dissatisfied in 38% of cases with number of sessions offered. About 23% of cases in this service were referred on to other agencies. The highest level of satisfaction was with clients who attended therapy for 5 sessions (Rogers, McLeod, & Sloboda, 1995). This dissatisfaction with the number of sessions offered by EAPs is an interesting result to consider when 90% of the services offer 6 sessions (Highley & Cooper, 1995) and that it is reported that clients can achieve significant benefits within 3-8 sessions (McLeod, 2001). This dissatisfaction with the scope of the service does not seem to affect the positive outcomes.

Following on from this research, Reynolds (1997) researched levels of satisfaction and improvement in another work-based public sector counselling service. He reports that there were high levels of satisfaction with the counselling provided and that there was an overall positive perception of the counselling service by both employees who have used and not used the service. The outcomes suggest that 80% of those who received counselling reported clinically significant change in depression, yet there was no effect on absenteeism or job satisfaction. This lack of effect on absenteeism stands out as differing from the majority of the other research presented on the effects of absenteeism following the implementation of an EAP programme

(Cooper, Sadri, T., & Reynolds, 1990; McLeod, 2001), although the lack of effect on employees' job satisfaction is consistent with other research (Cooper & Sadri, 1991; Cooper et al., 1990).

Research in the public sector has also been developed to measure the usefulness of counselling where employees are facing increased level of stress due to organisational change. In one study employees in a local authority/municipal-housing agency were offered counselling during a time of organisational change. The research provided a treatment group of employees who were offered 4 sessions of cognitive-analytical therapy followed by a review session compared to a control group on a waiting list. The results suggest that 98% of those who received counselling reported that it had been helpful, yet there was no effect on occupational stress as measured by the Occupational Stress Indicator (OSI) or the General Health Questionnaire (GHQ) or job satisfaction as rated by the employee (Iwi, Watson, Barber, Kimber, & Sharman, 1998). Although this research project has a control group and measures of change taken before and after counselling, there are several concerns regarding the results. Some of the concern would be for the disparity between the high level of positive change reported by the client and the lack of change on standardised stress measures. Also, it is difficult to compare this research with other results that measure the effectiveness of an on-going EAP programme. Iwi's (1998) research looks at the effect of an organisation in change and a one off intervention programme. It would

be hard to compare and contrast with a continuing, proactive EAP programme for all employees.

The most recent publication into the outcomes of providing counselling in the workplace at a local authority evaluates client improvements after counselling interventions. The majority of the employees involved in this research attended for 6 counselling sessions. It is reported that mental health, general stress, and work related stress improved significantly by the end of counselling. Interestingly, sickness absence increased post-counselling, but it would have been unlikely to accurately measure the effectiveness on sickness so soon after the completion of counselling. In self-rated reports employees rated improvements in effectiveness at work and coping ability post counselling (Alker, 2000).

There have also been several research publications measuring effectiveness of counselling provided to employees working in the stressful profession of health provision. One such research project evaluates the effectiveness of two counselling services available to National Health Service employees. The results suggest that there was a substantial reduction of levels of distress and symptomatology as measured by the GHQ12, psychiatric symptomatology, interpersonal problems, and coping strategies. The effect size between the measures taken between the time of entering counselling and the follow-up (at one, three, and six months following counselling) is >1.0. There was also a smaller but significant change in relationship

problems and coping strategies. The average levels of distress before counselling were similar to the level of distress experienced by psychotherapy outpatient clinical profiles. This report also suggests the greatest improvements with women and shift workers (Cheeseman, 1996). It is interesting to note that the levels of distress of employees accessing the EAP are similar to the levels experienced by psychotherapy outpatient units. This highlights that fact that employees are often suffering under great mental distress, and that this would impact on workplace functioning, even if the employee continues to attend the job during the distress.

Additional research conducted with health care professionals was conducted in a large London hospital. This research was designed to assess whether absenteeism rates were lower following stress counselling for health service workers. This research evaluated stress levels using an 8-item scale of mood and functioning before the start of counselling, at the last session, and at a six-month follow-up. The researcher reports significant improvements in anxiety, depression, and absenteeism. In relation to job satisfaction there was no change, which is consistent with previous research mentioned. The research reports a 44% improvement in absenteeism for the subjects in question (Mitchie, 1996). Although this research is consistent with previous research, it needs to be considered cautiously due to the missing data upon follow-up in relation to anxiety and depression. Perhaps only satisfied clients returned their follow-up questionnaires.

The most recent research of work based counselling within the health services was conducted by the Royal College of Nursing (2000). The research uses the CORE evaluation system to measure functioning before and at the end of counselling. The results suggest that pre-counselling distress levels were substantially above the normal population and slightly higher than CORE 'clinical population' norms. Post counselling levels returned to closer to normal (Royal College of Nursing, 2000). It is difficult to interpret these results due to a large proportion of clients not completing the end of counselling questionnaire. However, this research again highlights the high levels of distress that employees are displaying when contacting the EAP services, reinforcing the need to provide quality support services for employees.

It is interesting to note the significant improvement reported for workers within the health services regarding clinical functioning and satisfaction with the service within a stressful working environment. Another industry which is associated with high stress and is safety sensitive is the transportation industry. The need of organisations which provide transportation to be keenly aware of the problems of their staff that may cause a safety risk, like addiction to substances, are of huge importance. Guppy and Marsden's (1997) research into the effectiveness of alcohol misuse programmes within the transportation industry looks to establish the usefulness of these types of work based counselling and substance abuse programmes. The researchers

measured effectiveness of the service using standardised questionnaires administered at the time of referral and at a 6-month follow-up. They collected data in relation to job satisfaction, job commitment; self rated work performance, work stress, mental health (GHQ-12) and supervisor ratings of work performance along with data regarding absenteeism. The results showed a significant improvement in mental health (35% showing clinically significant levels of gain), improved client and supervisor ratings of work performance and reduced absenteeism. The results in relation to job commitment and satisfaction mirrored other research in showing no significant difference. Another service in Scotland, which received 80% of its referrals for alcohol-related issues, found that after treatment a greater number of employees stayed in their jobs, and thus recruitment and training costs for the companies involved fell considerably (McAllister & Bryan, 1993).

The pattern of employees improving clinically, being highly satisfied with the counselling they received, and absenteeism reducing seems to be reported consistently across research in various settings. The same type of results are reported by Goss and Mearns (1997) from a work based counselling service within education. They report that 65% of employees rated that counselling had improved their problems and 86% rated they were highly satisfied with counselling and significant levels of improvement in their self-esteem. The

sickness absence for this research showed a 62% improvement in absence for a 6-month period following counselling.

One of the problems in reviewing the research into the effectiveness of work based counselling services is the various types of intervention offered (Orlans, 1991). Some services offer a wide variety of counselling to address an extensive range of presenting problems where other services are specific to providing support though organisational change (Iwi, et al, 1998) or support in relation to substance abuse (Guppy & Marsden, 1997). An example of a service with a very specific type of intervention is Barkham and Shapiro's (1990) research into job-related stress. They report on a pilot study of brief therapy provided in a '2+1' format, meaning that two sessions of therapy were provided on consecutive weeks, followed by a third session three months later. The results using this type of intervention focused on white-collar employees referred for work-related problems by GPs or occupational health officers. Between 42 and 67% of employees showed reliable and clinically significant improvement after 2 sessions where 55 to 73% showed improvement at the 6 month follow-up as measured by the Beck Depression Inventory and the SCL-90L.

In a more extensive study using the '2+1' protocol in which employees would be randomly placed into three groups: cognitive-behavioural treatment, psychodynamic treatment, or waiting for four weeks before treatment was delivered, the results suggest that therapy

was effective for all groups. Levels of improvement were found in 67% of stressed employees, 72% of subclinical employees, and 65% of low-level clinically depressed clients. The employees who scored lowest before the intervention improved the most during treatment. Another interesting result was that the four-week delay for treatment did not seem to influence the level of improvement once treatment was started. The cognitive-behavioural intervention was no more effective than the psychodynamic-interpersonal during the course of treatment but seemed to be significantly more effective at the one-year follow-up (Barkham, Shapiro, Hardy, & Rees, 1999). One factor in the high level of change reported in this research is the fact that the base line measures were taken at a pre-treatment assessment instead of at the first therapeutic appointment. It is known that clients improve between initial contact and the first therapeutic appointment and this research captures this change in the results showing a strong improvement, where other publications use the first therapeutic session and the baseline.

After reviewing the wide variety of research produced within the UK over the past decade, there are some strong parallels that can be drawn as to the effectiveness of organisations providing work based counselling services. McLeod's (2001) recent systematic review of the research on work based counselling services worldwide draws some very interesting conclusions:

- The majority (over 90%) of employees who make use of workplace counselling are highly satisfied
- People who make use of workplace counselling typically display high levels of psychological distress
- Counselling interventions are generally effective in alleviating symptoms of anxiety, stress and depression
- Counselling interventions reduce sickness absence rates by 25-50%
- Counselling interventions seem to have less impact on job commitment, work functioning, job satisfaction, and substance misuse
- There is no evidence that any one approach to counselling is more effective than any other, although training and experience in brief therapy are associated with good outcomes in workplace counselling
- Significant benefits for clients can be achieved in 3-8 sessions of counselling
- Approximately 7% of employees will make use of counselling services provided
- Internal and external counselling services are equally effective
- Work based counselling services are cost effective and at least cover the cost of providing the service
- The demographics of employees do not seem to effect the level of usage

In brief, it can be concluded that work based counselling services are effective for companies to deal with the mental health of their employees and decrease absenteeism within the workplace (Cooper & Sadri, 1991; Firth & Shapiro, 1986; Goss & Mearns, 1997; Guppy & Marsden, 1997; Industry, 1992; McAllister & Bryan, 1993; Mitchie, 1996). Work based counselling services seem to be equally as effective internally or externally provided that a good level of employee uptake and high levels of satisfaction are consistently reported. In addition, the cost benefit to the organisation seems to show repeatedly that the cost of providing a work based counselling service is returned in reduced absence rates and other factors (Industry, 1992; Stephen & Bingaman, 1999).

The limitation to the research available on work based counselling in the UK is that the services that are described in the research vary in relation to the level and type of service that is being provided. This makes it very difficult to apply the results of one work based service to another. As reported some work-based services are primarily substance abuse programmes (Guppy & Marsden, 1997), others are short-term interventions for organisational change (Iwi, Watson, Barber, Kimber, & Sharman, 1998), where others are on-going work based EAPs offering varying degrees of intervention. It is therefore difficult to apply the results of one publication to another service, unless the services are similar in breadth and scope. It would be an interesting advance in the future of work based counselling

research to develop a research project that would be able to elicit the effective common factors of work based counselling. This would help professionals develop the most important aspects of the services that lead to positive support and change for the organisation.

It is surprising that with the research showing clear cost benefit analysis that all organisations do not provide a work based counselling service to support their staff. It seems repetitively clear from the results in the numerous research projects presented above that all types of interventions of work based counselling work: internal, external, and varying types of intervention are productive. Therefore it would be wise for organisations to take these findings on board and provide adequate support to employees at all levels within their organisation. Although the research strongly suggests that EAPs are a cost effective way to influence organisations in a positive way, it is estimated that only 12% of UK organisations use this type of benefit for their employees (Hopkins, 2001).

Although there is strong research supporting the use of employee assistance programmes, there are also concerns against the use of EAPs or counselling services. The establishment of a counselling service or EAP might be seen as having the potential to shift the responsibility for the health of an organisation's employees from the organisation to the individual. Companies which take on a counselling service may project employee stress onto their family and personal lives, and away from those factors which may be causing stress within the environment of the

organisation. It is, however, important that companies do not project their own internal problems onto employees, portraying them as being 'sick' and medicalising a problem which in fact originates within the organisation itself (Highley, 1996; Hopkins, 1994; Orlans, 1991; Reddy, 1993a; Sugarman, 1992). Secondly, some believe that counselling services and EAPs have a negative focus on treatment, as opposed to prevention. Only about 50% of counselling services or EAPs feed back information to the company they serve, in order to develop creative responses towards workplace change with a preventative agenda (Reddy, 1993a). Of these, only a small proportion go on to actually implement change. This reluctance to feed back information or to use the information correctly leads services away from the two fold benefit of EAP services: 1) support for the employee and 2) information regarding healthy change for the organisation.

Counselling in the workplace is a rapidly growing field, and therefore care must be taken to ensure that new companies providing counselling services are competent. In the light of the factors dealt with above, it is highly desirable that the various EAP/workplace counselling providers which operate in the UK market collaborate on the task of research, as well as in the development of professional ethics and qualifications. If therapy/counselling practitioners in the UK manage to work together successfully, the profession will be able to develop answers to organisational demands for the most effective strategies for

supporting employees with personal or work anxieties, so as to help them be more productive in the workplace.

Reddy (1993) compares the growth of counselling in the workplace to the growth of the Information Technology (IT) field. Many years ago IT appeared to promise more than it could deliver and its promises seemed beyond the comprehension of the average person. While IT projects ate into large proportions of the annual budget of many companies, their returns were seen as uncertain and difficult to quantify, and only large companies could afford to invest heavily in IT. Similarly, counselling services and EAPs are often misunderstood in the present climate by management and viewed sceptically because their ultimate impact on any company appears to be hard to quantify with any degree of accuracy. If the counselling profession wants the growth of counselling to replicate the ever-increasing expansion rate enjoyed by the IT field, it needs to create systems that will facilitate the easy exchange of information back into the organisations it services, and demonstrate to UK business, with the aid of research and statistics, that counselling can - like IT - be cost-effective and fit into organisations of all sizes.

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